IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER

Complaint Intake #: 48567-C, 48629-C, 48742-I, 48705-I

July 1, 2014

Ms. Nicole Ellermeier, Executive Director
Whispering Creek Assisted Living
2609 Nicklaus Blvd
Sioux City, IA 51106

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT – WHISPERING CREEK ASSISTED LIVING
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Ellermeier:

I. Final Complaint/Incident Investigation Report – Whispering Creek Assisted Living

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **June 17, 18 and 19, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Policy and Procedures, Evaluations and Service Plans.

Whispering Creek Assisted Living ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.17(1)(b), 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.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) 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 Evaluations and Service Plans.

The determination of a **$1,000 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Evaluations and Service Plans. As the enclosed Report details the Program failed to complete comprehensive evaluations and update service plans to meet the needs of the tenants.

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 481–67.17(5).

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 **six hundred and fifty dollars ($650)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to the document enclosed for more information.

IV. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

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 as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Nicole Ellermeier, Executive Director
Whispering Creek Assisted Living
2609 Nicklaus Blvd.
Sioux City, IA 51106

Complaint/Incident Intake #: 48567-C
48629-C
48742-I
48705-I

Date of Complaint/Incident Investigation:

June 17, 18, and 19, 2014

Monitor(s):

Lori Miner, RN BSN

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

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

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

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

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

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

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	32
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	35
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	46

Program History – The program received regulatory insufficiencies in the areas of: Tenant Rights, Tenant Documents, Evaluation, Criteria for Admission and retention of tenants, Service Plans and Record Checks,

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged two tenants in the dementia unit were found in bed with clothes off (48657-C). It was alleged two tenants in the dementia unit had sexual contact (48629-C). The program reported two tenants were found in their underwear in one of the tenant's apartments (48742-I)

- Monitoring Observation: Tenant #1, an 84 year-old, was admitted to the general population portion of the assisted living program on 4-2-12. Tenant #1 had diagnoses of: Hypertension, Depression, and Dementia. On 3-11-14 Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline.

  According to a report by the Department during an October 2013 visit, Tenant #1 was transferred to the dementia unit on 6-17-13 and had been in an intimate relationship while a tenant in the general population section of the program. The other tenant also transferred to the dementia unit and desired the intimate relationship to continue. The other tenant was eventually given a 30-day notice for behaviors.

Tenant #2, a 90 year-old, was admitted on 3-29-14 and had diagnoses of: Hypertension, Atrial Fibrillation, Chest Pain, Chronic Kidney Disease, and Gout. Tenant #2 was staged at four on the GDS which indicated moderate cognitive decline. A note was sent to the physician on 4-16-14 requesting to enact the Durable Power of Attorney for medical purposes, as it was not believed Tenant #2 could make safe decisions regarding medical care.

On 4-29-14 clinical notes for Tenant #1 and #2 documented the Divisional Nurse spoke with both tenants regarding a relationship that had evolved between the two. Tenant #1 did not know the name of the other tenant and thought the two of them had just met each other that day and were friends. It was documented Tenant #1 was unhappy that staff was keeping them apart. Tenant #1 stated to the Divisional Nurse that nothing would happen, that Tenant #1 didn't want to happen.

In an interview with the Divisional Nurse, she stated she was asked by the RN to sit down and determine how the relationship between Tenant #1 and #2 was perceived. The Divisional RN determined it was a friendship, occasionally holding hands, and attending meals and activities together. The Divisional Nurse reported Tenant #1 had a GDS of 5 and Tenant #2 a GDS of 4, and that friendship in the common areas was ok. The Divisional Nurse asked the RN to follow up with the families.

Clinical notes for both Tenant #1 and #2 dated 5-1-14 documented it was ok for Tenants #1 and #2 to hold hands and do things in the common areas together such as activities, eating, and walking, but the tenants could not be engaged in inappropriate touching or kissing, and the tenants could not go into each other's apartment, and could not shower or sleep together. The service plans were to be updated to include the interventions.

The clinical notes for Tenant #1 and #2 dated 5-2-14 documented the staff overheard Tenant #2 stated "they are all up there so I am coming to your room." Tenant #2 closed the door. Staff opened it to find Tenant #1 and #2 kissing. Staff asked the tenants to come out to the common area, and the tenants agreed.

Two incident reports dated 5-26-14 documented Tenants #1 and #2 were found in Tenant #1's apartment in an "inappropriate manner." The incident reports were completed by Staff #1. Staff #1 stated on 5-26-14 between 7:00 and 7:30 p.m. she went to give Tenant #2 medications. At that time Tenant #2 was not in the apartment. Staff #1 went to Tenant #1's apartment and opened the door. Staff #1 observed Tenant #2 on top of Tenant #1. Tenant #2 rolled off, grabbed his/her heart and indicated chest pain. Staff #1 asked Tenant #2 if he/she was ok, then radioed for Staff #2. Tenant #2 asked Staff #1 if there would be "hell for this" then denied chest pain. Staff #1 then observed Tenant #1 with a blanket over the face and underwear down to the ankles.

Staff #1 took Tenant #2 to Tenant #2's apartment, and took vital signs. Staff #1 reported getting each tenant settled into their own apartment, but Tenant #2 kept trying to sneak into Tenant #1's apartment.

Staff #2 was interviewed. Staff #2 stated on 5-26-14 she had helped Tenant #1 get to bed early because Tenant #1 reported being tired. Shortly before 7:00 p.m. Staff #1 asked for Staff #2. Staff #2 reported the only restrictions at the time for Tenant #1 and #2 was the tenants were not to be in each other's apartments. Staff #2 walked into Tenant #1's apartment and saw Tenant #1 lying on the bed with a blanket over the head. The underwear was down to the ankles. Tenant #2 was sitting in a chair. Tenant #2 had pants and belt undone. Staff #1 reported Tenant #2 was on top of Tenant #1 and Tenant #2 rolled to the floor when Staff #1 walked in. Staff #2 stated she would call the RN. Staff #2 reported to the RN the incident including Tenant #2's pants were unzipped and the underwear was down slightly. Staff #2 reported when the tenants were asked if they had sex, Tenant #1 reported "I guess you could call it that" and Tenant #2 stated "we started but you interrupted us." The RN instructed the tenants be separated.

Staff #2 reported it was difficult to get Tenant #2 to leave Tenant #1's apartment. Tenant #2 wanted to sit on a bench outside Tenant #1's apartment. Staff #2 got Tenant #1 dressed and Tenant #1 went to sleep.

The clinical notes 4-29-14 and 5-1-14 documented Tenant #2 was educated by the RN that Tenant #2 and Tenant #1 were able to continue to sit and talk in the commons area, dining room, that it was ok for Tenants #1 and #2 to hold hands; however it was not ok for the tenants to enter other tenants apartments.

According to the clinical notes dated 5-27-14, Tenant #1 was to have the door handle lock on the outside so that Tenant #1 could leave the apartment at any time, but would need a key to get in.

Staff #1 reported after the 5-26-14 incident a lock was placed on Tenant #1's door. Tenant #1 could not get into the apartment without assistance from a staff member who had a key to the door. Staff #1 reported it was hard at dinner time because Tenant #1 finished dinner early and could not get into the apartment.

Staff #2 stated a lock was placed on Tenant #1's door which allows Tenant #1 to leave, but Tenant #1 cannot enter the apartment without asking someone for the key. Staff #2 reported Tenant #1 is used to going into the apartment to use the bathroom and now has to ask to get in.

Staff #4 stated Tenant #1 did not remember the door to the apartment was locked until trying to open it. Staff #4 stated staff tried to watch Tenant #1 and unlock the door when Tenant #1 walked towards the apartment.

Clinical notes for both Tenants #1 and #2 dated 6-13-14 for 6-12-14 documented staff walked into Tenant #2's apartment and found Tenant #1 in the apartment dressed with a top and underwear on. Tenant #2 was sitting in a chair with a shirt and underwear on with pants at the ankles.

Staff #3 was interviewed and stated she was working the evening of 6-12-14. As Staff #3 was doing laundry and keeping another tenant occupied, Staff #3 had seen Tenant #1 and #2 sitting in the living room of the dementia unit. Staff #3 came out of a tenant's apartment and Tenant #1 and #2 were no longer sitting in the living room.

Tenant #2's door was shut. Staff #3 did not recall a time, but did not think it had been long since seeing Tenants #1 and #2. During a follow-up interview, Staff #3 thought it could not have been more than 10-15 minutes. Staff #3 walked into Tenant #2's apartment. Tenant #2 stated "you're not supposed to just walk in, you're supposed to knock." Tenant #1 was standing in the middle of the room and only had a top and underwear on. Tenant #2 was in a recliner in the corner of the room with a top and underwear on, and was trying to get pants up from the ankles. Staff #3 radioed for Staff #1. Staff #3 asked Tenant #1 where the pants were and Tenant #1 did not know. Staff #3 walked into the bathroom to look for the pants. Tenant #1's face was flushed. Staff #3 found the pants on the bed and handed them to Tenant #1 to put on.

According to Staff #3, Staff #1 arrived. Staff #1 asked Tenant #2 what was going on and Tenant #2 replied it was a love affair. The RN was notified. Staff #3 completed an incident report which indicated the time of the incident was 3:50 p.m. The incident report documented Staff #3 saw Tenant #1 stumble and looked at Staff #3 as if afraid.

In an interview with Staff #1, she stated she was radioed by Staff #3. Tenant #1 was standing by the bathroom, the bed was undone, and Tenant #2 was in the chair. Both tenants were dressed when Staff #1 arrived. Staff #1 directed the RN and Executive Director be notified. Staff #1 reported she asked Tenant #2 if the two had sex and Tenant #2 replied "we were going to until you barged in." Tenant #2 reported they were in love. Tenant #1 stated "I didn't like it." Staff #1 stated she was directed to observe the bed and the clothing. Staff #1 stated clothing and the bed were dry.

According to the clinical notes for Tenant #2 indicated the RN asked Tenant #2 if it was ok to have other tenants in the apartment to which Tenant #2 replied, "No." The family was notified and a verbal 30-day notice was given, which was followed by a written 30-day notice on 6-18-14.

In an interview with Tenant #1's family it was reported the family was notified of the incidents and was aware of the lock on the door. The family stated the program had to do "what they had to do." The family also stated this was not the first relationship Tenant #1 had while living at the program.
Interventions instituted according to Tenant #2's clinical notes of 6-13-14 included not sitting with a tenant of the opposite sex unless a staff member or caregiver was present, Tenant #2 was not to go into other apartments or have tenants into Tenant #2's apartment, and Tenant #2 was not allowed to hold hands or touch a tenant of the opposite sex.

Tenant #2 left the program on 6-19-14.

Tenant #1 had a lock placed on the apartment door following an episode of 5-26-14 where Tenant #2 was found in Tenant #1's apartment after Tenant #1 had been put to bed for the evening. The lock allowed Tenant #1 to leave the apartment but Tenant #1 could not enter without a key. The lock was instituted as a safety measure for Tenant #1. Staff members had a key to the lock. According to the service plan dated 3-17-14, current at the time the lock was applied, indicated Tenant #1 was independent with ambulation and toileting.

Staff #1 and #2 were interviewed and indicated Tenant #1 had to ask to get into the apartment, and was sometimes difficult to anticipate Tenant #1's needs at meal time. Staff #4 reported Tenant #1 forgot the door was locked and staff had to watch for Tenant #1 to walk towards the apartment. Tenant #1 was not autonomous in seeking entry into Tenant #1's own apartment.

Concerns were noted regarding tenant rights violations. This occurred when staff entered Tenant #1's and Tenant #2's rooms without knocking or asking permission to enter after identification of the incidents that occurred between Tenant #1 and Tenant #2. The Tenants still have rights to dignity and autonomy even following the incident that occurred on 5/26/14.

- 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))

B. Policies and Procedures

Complaint/Incident Allegation: It was alleged documentation was altered related to an interaction between two tenants. (48629-C)

- Monitoring Observation: Two incident reports dated 5-26-14 documented Tenants #1 and #2 were found in Tenant #1's apartment in an "inappropriate manner." The incident reports were completed by Staff #1. Staff #1 reported her position as Medication Manager who worked in the dementia unit. Staff #1 stated on 5-26-14 between 7:00 and 7:30 p.m. she went to give Tenant #2 medications. At that time Tenant #2 was not in the apartment. Staff #1 went to Tenant #1's apartment and opened the door. Staff #1 observed Tenant #2 on top of Tenant #1. Tenant #2 rolled off, grabbed his/her heart and indicated chest pain. Staff #1 asked Tenant #2 if he/she was ok, then radioed for Staff #2. Tenant #2 asked Staff #1 if there would be "hell for this" then denied chest pain. Staff #1 then observed Tenant #1 with a blanket over the face and underwear down to the ankles.

  Staff #1 stated Staff #2 asked Tenant #1 if Tenant #1 and #2 had sex, to which Tenant #1 replied "yes you could call it that; I didn't like it." Tenant #1's face was covered. Tenant #1 was reported to seem upset and startled and did not know who the other tenant was. Tenant #2 indicated they were just starting to have sex. Tenant #2 was outraged and angry, knew he/she should not be doing that, and staff interrupted, according to Staff #1.

  Staff #1 heard Staff #2 tell the RN by phone that Tenant #2 was on top of Tenant #1. Staff #1 stated she heard Staff #2 tell the RN what the tenants had said, that they were having sex. Staff #1 reported Staff #2 called the RN who instructed Tenant #2 be removed from Tenant #1's apartment.

  Staff #1 reported Tenant #2's pants were up, but the top of the pants were undone. Staff #1 heard Staff #2 tell Tenant #2 to fix the pants. Staff #1 stated she did not see Tenant #2's genitals. Staff #1 stated she could not say if penetration did or did not occur. Staff #1 took Tenant #2 to Tenant #2's apartment, and took vital signs.

Staff #1 reported getting each tenant settled into their own apartment, but Tenant #2 kept trying to sneak into Tenant #1's apartment.

Staff #2 informed Staff #1 that incident reports needed to be completed. Staff #1 stated she was not sure how to write an incident report, and stated she followed instructions provided by Staff #2. Staff #2 stated she wrote the incident reports dated 5-26-14.

Staff #1 reported the next day she went to talk to the RN who instructed Staff #1 to write the full story of the incident on notebook paper. According to Staff #1, the RN stated she had not been told Tenant #1 was upset and that Tenant #2's pants were undone. According to Staff #1, the RN then put the Executive Director on speaker phone to hear the conversation. According to Staff #1 she approached the RN because of questions. The RN and Executive Director confirmed they were notified of further details of the incident.

Staff #1 reported the documentation on the piece of paper was written "a couple days" later. Staff #1 was asked about documentation in the clinical notes for Tenant #1 and #2. Entries in each chart documenting the 5-26-14 incident indicated Tenant #2 had panties down to the ankle. Tenant #1's clinical notes indicated Tenant #2's had clothing on and pants were zipped. Staff #1 stated if the RN referenced the incident reports, the information in the clinical record was factual. The information on the later-submitted piece of paper contained more detail.

Staff #1 also reported Tenants #1 and #2 were not to be in apartments alone together, but could be near each other if staff members were present.

Staff #2 was interviewed. Staff #2 stated on 5-26-14 she had helped Tenant #1 get to bed early because Tenant #1 reported being tired. Shortly before 7:00 p.m. Staff #1 asked for Staff #2. Staff #2 reported the only restrictions at the time for Tenant #1 and #2 was the tenants were not to be in each other's apartments. Staff #2 walked into Tenant #1's apartment and saw Tenant #1 laying on the bed with a blanket over the head. The underwear was down to the ankles. Tenant #2 was sitting in a chair. Tenant #2 had pants and belt undone. Staff #2 stated she could see Tenant #2's genitals through a hole in the underwear. Staff #2 stated she asked Staff #1 what she saw. Staff #1 reported Tenant #2 was on top of Tenant #1 and Tenant #2 rolled to the floor when Staff #1 walked in. Staff #2 stated she would call the RN. Staff #2 reported to the RN the incident including Tenant #2's pants were unzipped and the underwear was down slightly. Staff #2 does not recall if she reported the penis was erect. Staff #2 reported when the tenants were asked if they had sex, Tenant #1 reported "I guess you could call it that" and Tenant #2 stated "we started but you interrupted us." The RN instructed the tenants be separated and to check Tenant #2's vital signs because of a history of an elevated blood pressure.

Staff #2 reported Staff #1 wrote out the incident reports because Staff #1 was the one who initially found Tenants #1 and #2 together. Staff #2 reported incident reports were to be detailed. Staff #2 reported Staff #1 had told her the details had been written on a separate piece of paper. The next day the RN called Staff #2 and asked if Tenant #1 was upset to which Staff #2 replied Tenant #1 had a blanket over the head.

The RN was interviewed and stated incident reports were to be completed as close to the time of the incident as possible, and before the staff member left at the end of the shift. The RN stated she notified the family and physician of any incidents. The RN stated separate pieces of paper were not completed with incidents and that she was not provided with any other written statement of the events of 5-26-14.

Staff #1 reported filling out an incident report following an encounter between two tenants on 5-26-14. Staff #1 stated she thought the report was not to be detailed. Staff #1 later spoke with the RN and the Executive Director regarding details of the incident. Clinical records documented Tenant #1 was found with underwear at the ankles and Tenant #2 was on top of Tenant #1. Staff #1 stated the documentation in the clinical record was accurate based on the information contained in the incident report.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: The program reported a tenant who resided in the dementia unit had gotten out of the building because a door was not latched (48705-I).

- Monitoring Observation: Tenant #3, a 76 year-old, was admitted on 4-12-11 and had diagnoses of: Alzheimer's disease and Anxiety State. Tenant #3 resided in the secured dementia unit.

  According to clinical notes dated 3-13-14 and 4-30-14, Tenant #3 was found outside the dementia unit and within the general population portion of the building. The clinical notes also documented the laundry room door was not latched tightly. In an interview with the RN, she reported the tension on the laundry room door was tightened so that the door would spring shut and secure itself. The laundry room door was always locked and cannot be unlocked according to the RN.

  According to clinical notes dated 5-1-14, staff members were to make sure all exiting doors in the dementia unit were latched at shift change and whenever entering and exiting the dementia unit.

  In the clinical notes of 5-1-14, Tenant #3 was described as a wanderer but not exit seeking. Tenant #3 picked and pushed on various things including doors. Staff members were to try to engage Tenant #3 in an activity.

  In an interview with the RN she stated Tenant #3 was always touching things, and feels things while walking. The RN stated Tenant #3 did not routinely set off door alarms. If a door was open, Tenant #3 would go through it.

  The Activities Assistant was interviewed. She stated Tenant #3 wandered, stood and picked at walls and painting, lay on the floor and didn't talk much. The Activities Assistant reported on a Friday, the nursing staff was in a meeting. The Activities Assistant was in the dementia unit with the tenants showing a movie. Tenant #3 was wandering. The Activities Assistant reported after the staff meeting she reported to the oncoming staff that Tenant #3 was wandering.

The Activities Assistant reported she left the dementia unit at 3:05 p.m. and Tenant #3 was in the dementia unit at that time. Tenant #3 was dressed. The Activities Assistant reported she went into the general population to assist with another activity. The Activity Assistant did not recall the time, but a tenant from the independent living section of the building reported to her that a tenant was outside on the patio of an apartment. The Activities Assistant went to the patio and found Tenant #3. Tenant #3 was easily redirected back to the dementia unit. The Activities Assistant reported the door leading out of the dementia unit was not shut all the way. It was reported this particular door, located in the dining room of the dementia unit, was a little-used door.

In an interview with the Executive Director, she stated staff members were interviewed following the incident with Tenant #3 on 6-6-14, but the interviews did not provide information on what happened. The Executive Director stated if the code was entered on the door, the alarm would not sound. It was reported the door Tenant #3 was thought to exit from was not a commonly used door.

The surveyor was accompanied to the door by the LPN. The door was locked and alarmed. At the request of the surveyor, the LPN entered the code to unlock the door. The door was opened. When the door was pushed open, the door slammed shut and latched. When the door was pushed open lightly and returned slowly, the door did not latch and the alarm did not sound because the code had been entered.

The surveyor estimated the distance from the dementia unit door to the patio to be 75 feet.

According to the clinical notes of 6-6-14, the activities staff was notified at 3:15 p.m. that Tenant #3 was outside of the dementia unit.

The State Climatologist reported at 2:52 p.m. on 6-6-14 the weather in Sioux City was 83 degrees with winds out of the south at eight miles per hour and clear skies. The heat index was 83 degrees.

The program provided a copy of the Change of Shift Report policy which indicated all alarmed doors were to be checked to make sure the doors were alarmed. Tenants were also to be accounted for at shift change.

The program also provided documentation dated 4-29-14 which indicated all staff were to ensure that all doors in the dementia unit were to be checked to make sure the door closed and doors were closing properly at shift change and when entering and exiting the dementia unit.

Tenant #3 was seen at 3:05 p.m. by the Activities Assistant as she left the dementia unit following her coverage of the unit for a staff meeting. At 3:15 p.m., the Activities Assistant was notified Tenant #3, who resided in the dementia unit, was on the patio of a tenant who resided in independent living. A door leading out of the dementia unit was found to be unlatched.

The program's policy and procedure on checking doors was not followed.

- 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 have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

C. Evaluation

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

Monitoring Observation: The clinical notes for Tenant #1 dated 5-27-14 documented Tenant #2 was lying on top of Tenant #1. Tenant #1 had underwear down to the ankles. Tenant #1 looked upset and had the covers over the face. Tenant #1 started crying after staff intervened. The clinical notes of 5-27-14 documented Tenant #1 was able to continue talk and hold hands in the commons area and dining room but was not to be in other tenant's apartments following the 5-26-14 incident. There was no documentation that the RN evaluated Tenant #1 immediately after the incident occurred.

The clinical notes of 5-27-14 documented RN spoke with Tenant #1 regarding the incident on 5-26-14 and that family for Tenant #1 was notified of the incident. Tenant #1 recalled a tenant had been in the apartment the night before, but said nothing else. It was documented Tenant #1 showed no signs of harm and voiced no concerns, but evaluations of function, cognition, and health were not completed after Tenant #2 was found on top of Tenant #1 in an "inappropriate manner."

Prior to entering the assisted living program, Tenant #2 had resided in an independent living program. The Director of Nursing (DON) at the Independent program was contacted. Tenant #2 was discharged because Tenant #2 was driving a vehicle at 3:00 a.m. and would get lost. The family was asked to provide a caregiver to monitor Tenant #2's leaving the apartment to drive. The DON stated Tenant #2 did not exhibit any physical, verbal aggression or sexually inappropriate behaviors.

On 4-14-14, clinical notes documented Tenant #2, residing in the general population of the program, was reported to be wrapped up in blankets sitting on the couch, believing it was a garage. The program instituted one-hour checks until Tenant #2 could be moved to the dementia unit. Tenant #2 was noted to be disoriented to time and place. Tenant #2 was moved into the dementia unit on 4-18-14.

Staff #2 reported she asked Tenant#1's age, and Tenant #1 replied "18." Tenant #1 pointed to Tenant #2 and referred to Tenant #2 as a boyfriend/girlfriend. Staff #2 reported seeing Tenant #1 and #2 sitting next to each other at meals or sitting on the couch visiting. The relationship progressed to holding hands and kissing. Staff #2 reported Tenant #2 was very aware of staff member's location within the unit. After meals, Tenant #2 would stand behind Tenant #1's chair and say, "Let's go." Tenant #1 would get up and leave with Tenant #2. Staff members would tell Tenant #1 it was ok to finish the meal, and sometimes Tenant #1 would not eat out of worry as to what Tenant #2 was doing.

Clinical notes for both Tenants #1 and #2 dated 6-13-14 for 6-12-14 documented staff walked into Tenant #2's apartment and found Tenant #1 in the apartment dressed with a top and underwear on. Tenant #2 was sitting in a chair with a shirt and underwear on with pants at the ankles.

There was no documentation of evaluation completed for Tenant #1 related to Tenant #1 and #2's relationship to determine the capability of the tenants to continue the relationship.

There was no documentation of evaluation completed for Tenant #2 related to Tenant #1 and #2's relationship to determine the capability of the tenants to continue the relationship

- 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))

D. Service Plans

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

- Monitoring Observation: Clinical notes for both Tenant #1 and #2 dated 5-1-14 documented it was ok for Tenants #1 and #2 to hold hands and do things in the common areas such as activities, eating, and walking, but the tenants could not be engaged in inappropriate touching or kissing, and the tenants could not go into each other's apartment, and could not shower or sleep together. The service plans were to be updated to include the interventions.

  The service plan for Tenant #1 dated 3-11-14 was not updated with the interventions. The service plan did not meet the identified needs of Tenant #1.

  On 5-26-14, Tenant #2 was found on top of Tenant #1. Tenant #1's underwear was at the ankles. The service plan dated 3-17-14 was not updated after the 5-26-14 incident to include direction for staff related to hand-holding in the commons area and dining room, and intervention if Tenant #1 was entering other tenant's apartments. The service plan did not meet the identified needs of Tenant #1.

  According to the clinical notes dated 5-27-14, Tenant #1 was to have the door handle lock on the outside so that Tenant #1 could leave the apartment at any time, but would need a key to get in. The service plan was not updated with the door lock intervention until 6-9-14. The service plan did not meet the identified needs of Tenant #1

According to the clinical notes dated 6-5-14, Tenant #2 had an appointment with a dermatologist which resulted in an incision on the right clavicle. Clinical Notes dated 6-6-14 documented blood was seeping out between two of the sutures along the incision. A moderate amount of blood had gone through two gauze pads. Tenant #2 was seen at the physician's office after Tenant #2 had called the physician to report "bleeding out for over 24 hours." Tenant #2 was seen at the physician's office and more sutures were added along the incision. The service plan did not identify Tenant #2 had a dressing on the chest area and did not identify staff observations to report to the nurse related to a wound that showed a "moderate amount of bleeding." According to the service plan dated 4-18-14, staff was to ensure Tenant #2 got into and out of the shower safely. The service plan did not identify care of the dressing during bathing. The service plan did not meet the identified needs of Tenant #2.

According to clinical notes dated 3-13-14 and 4-30-14, Tenant #3 was found outside the dementia unit and within the general population portion of the building. On 6-6-14, Tenant #3 was found outside the building on the patio of a tenant that resided in Independent Living.

The clinical notes also documented the laundry room door was not latched tightly. In an interview with the RN, she reported the tension on the laundry room door was tightened so that the door would spring shut and secure itself. The laundry room door was always locked and cannot be unlocked according to the RN.

In the clinical notes of 5-1-14, Tenant #3 was described as a wanderer but not exit seeking. Tenant #3 picked and pushed on various things including doors. Staff members were to try to engage Tenant #3 in an activity.

In an interview with the RN she stated Tenant #3 was always touching things, and feels things while walking. The RN stated Tenant #3 did not routinely set off door alarms. If a door was open, Tenant #3 would go through it.

On 5-15-14, 90-day evaluations were completed and a service plan was completed. The service plan of 5-1-5-14 did not identify the intervention put in place as indicated in the 5-1-14 clinical note which stated staff was to engage Tenant #3 in an activity when wandering and picking and pushing on things. The 5-15-14 service plan, current as of the incident of 6-6-14, was not updated until 6-9-14 following the third time Tenant #3 walked out of the dementia unit. The service plan did not meet the identified needs of Tenant #3.

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