IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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321 East 12th Street
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
51259-I

January 13, 2015

Mr. Kent Walton, Director
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233

RE: Final Complaint/Incident Investigation Report, Promise House, Hiawatha, Iowa

Dear Mr. Walton:

Enclosed is the **Final Complaint/Incident Investigation Report** completed 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 **December 29 & 30, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Criteria for Admission and Retention.

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.

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 rule 67.14 for more information.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0090	A. BUILDING. _____ B. WING _____	C 12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

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A 000	481-69 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by DedicationNumber of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 18 Total Population of Program at time of on-site: 18 TOTAL census of Assisted Living Program: 18 The following insufficiencies were cited during the investigation of Incident # 51259-I.	A 000		
A 040	481-69.23(1)c(1) Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the program did not always meet the criteria for admission and retention of tenants. Concerns were noted for one tenant (#1) who, despite intervention, showed ongoing physical aggression	A 040		

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A 040	Continued From page 1 and abusive behavior. The program reported a census of 18 tenants. Findings include: According to documentation in the medical record, Tenant #1 was admitted to the program on 09-25-2014 and had diagnoses which included Alzheimer's, dehydration, failure to thrive and hypertension. According to the programs "global deterioration scale" assessment dated 12-10-2014, Tenant #1 scored 6 (of 7) indicating severe cognitive decline/moderately severe dementia. Documentation in the programs functional assessment, dated 12-10-2014, indicated Tenant #1 was able to transfer and ambulate without assistance, remained continent of bowel and bladder and was able to eat independently. Tenant #1 required staff assistance with bathing, dressing and grooming. Documentation in a 30 day assessment (nurse review) dated 10-22-2014 indicated Tenant #1 received assistance of one staff for all ADL's (activities of daily living) . During the initial 30 day's Tenant #1 has been somewhat aggressive toward staff, and initially a couple of tenants, to the point of slapping staff in the face, and hitting tenant's in the back of the head, as well as hitting another staff when attempting to intervene. New medications were ordered and after being on the medications the behaviors subsided, and Tenant #1 became pleasant and quite talkative. On this date, staff indicated Tenant #1 had settled quite well into the program, despite a few initial behaviors that had since been corrected with medications.	A 040		

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A 040	Continued From page 2 According to documentation in the programs "occurrence log" and "occurrence reports", Tenant #1 exhibited the following after Tenant #1's initial 30 days: 11-21-2014 - Tenant #1 slapped staff on their arms 11-27-2014 - Tenant #1 laying in another tenant's bed. Staff assisted Tenant #1 out of the room and at that time Tenant #1 struck staff knocking glasses off staff's face. 12-02-2014 - Tenant #1 hit another tenant twice today; tenant immediately redirected. 12-08-2014 - Tenant #1 hit staff in the face and also came up behind staff and began striking staff 12-10-2014 - Tenant # 1 was up all night and hit staff 12-14-2014- Tenant #1 attempted to hit another tenant 12-18-2-14- Tenant #1 struck another tenant (#2) and staff found Tenant #1 and Tenant #2 on the floor. Tenant #2 had apparent head and facial injuries. Documentation in the 90 day assessment (nurse review dated 12-10-2014) indicated Tenant #1 had numerous behaviors (that initially subsided for about one month) and then began again. In addition to generalized hitting, scratching, and slapping of staff, and occasionally another tenant, Tenant #1 also started undressing. This new behavior was brought to the attention of Tenant #1's POA (power of attorney) and discussed in detail. Also during this period, numerous interventions had been attempted. A UA (urinalysis) was obtained and was negative. An extra dose of Haldol was ordered and staff provided one on one with Tenant #1. Medications have been changed again and are in the initial days of using those medications. Adaptive clothing has been discussed/suggested, however	A 040		

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A 040	Continued From page 3 the POA has still not purchased the clothing. Overall there had been significant decline in Tenant #1's overall mental functioning. Physical functioning is also declining to the point where Tenant #1 is going to need to use a walker or cane for safety and also have assist of staff for ambulation. Documentation in the nurse's notes dated 12-18-2014 at 8:20 a.m. indicated Tenant #1 was repeatedly hitting another tenant ' door when that tenant (#2) opened the door and Tenant #1 repeatedly hit and scratched Tenant #2 in the face. When tenant #2 raised his/her arms both tenants fell to the floor with Tenant #2 hitting his/her forehead and eye on the railing causing deep cuts. Tenants #1 and #2 were immediately separated and staff stayed with each tenant individually. Staff received physician's orders to send Tenant #2 to the emergency room for stitches and physician's orders to send Tenant #1 to the hospital for a psychiatric evaluation. During an interview on 12-30-14 at 9:31 a.m. Staff A described Tenant #1 as able to get "very rough" with other tenants and staff. Staff A stated Tenant #1 required one on one staff, indicating Tenant #1 could not be left alone; staff always had an eye on Tenant #1. Staff A stated Tenant #1 went after staff and tenants a couple of times a day, and after awhile, Tenant #1 went after mostly staff. Staff A stated the program should have had a psychiatric evaluation for Tenant #1 earlier. During an interview on 12-30-14 at 9:47 a.m. Staff B described Tenant #1 as being everywhere, very aggressive and attacked (staff) verbally. Staff B stated Tenant #1 was known to be aggressive, and some (interventions) worked for	A 040		

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