Iowa Health Care Association
Iowa Center for Assisted Living
Iowa Center for Home Care

Disciplinary Action Summary & Guidance
Iowa Board of Nursing Home Administrators

IHCA's Regulatory & Legal Team Work Group

January 2020

www.iowahealthcare.org | 515.978.2204

GUIDANCE FOR LICENSED NURSING HOME ADMINISTRATORS PRACTICING IN IOWA

The Iowa Board of Nursing Home Administrators is responsible for overseeing licensing, compliance and discipline relating to Iowa licensed nursing home administrators. The Board has filed disciplinary actions against twenty administrators over past ten years.

The Board commences investigations based on complaints filed with the Board as well as a review of certain survey findings which are automatically sent by DIA to the Board (all Class I, II and III citations). The Board does not investigate all survey findings, but certainly has focused on serious or repeated regulatory noncompliance including allegations of resident abuse.

If the Board chooses to file disciplinary charges against an administrator, that administrator has the right to request a formal administrative hearing. Despite that right, nineteen of twenty administrators facing disciplinary charges over past decade have chosen to forgo their right to a hearing and enter into a settlement agreement which results in the issuance of a Consent Order, resolving the charges. Functions of cost, time and certainty of outcome are factors in agreeing to settle.

While every settlement agreement is different, most follow a pattern with the administrator agreeing to a combination of the following: some form of probation, which may include reporting obligations or the issuance or periodic reports or sworn statements attesting to compliance with all of the terms and conditions of the settlement agreement, additional continuing education, mental, physical, or clinical competency examination or alcohol or drug screening, and payment of a civil penalty (fine).

DISCIPLINARY RULES - IOWA BOARD OF NURSING HOME ADMINISTRATORS

It is important for administrators to review the administrative rules relating to grounds for discipline which are found at 645 I.A.C. Ch. 144: https://www.legis.iowa.gov/docs/iac/rule/03-21-2012.645.144.2.pdf

Some of the more significant rules which have served or would likely serve as a basis for discipline include:

- 144.2(3) Professional incompetence. Professional incompetence includes, but is not limited to:

  a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

  b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other nursing home administrators in the state of Iowa acting in the same or similar circumstances.

  c. A failure to exercise the degree of care which is ordinarily exercised by a nursing home administrator acting in the same or similar circumstances.

  d. Failure to conform to the minimal standard of acceptable and prevailing practice of a licensed nursing home administrator in this state.

  e. Inability to practice with reasonable skill and safety by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or other type of material or as a result of a mental or physical condition.

- 144.2(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of nursing home administration or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

- 144.2(7) Habitual intoxication or addiction to the use of drugs.

- 144.2(8) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

- 144.2(9) Falsification of client or patient records.

- 144.2(11) Misappropriation of resident funds or facility funds.

- 144.2(12) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care including improper delegation of duties or supervision of employees or other individuals, whether or not injury results, or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

- 144.2(13) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice within the profession, regardless of whether the judgment of conviction or sentence was deferred. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

- 144.2(14) Violation of a regulation, rule or law of this state, another state, or the United States, which relates to the practice of nursing home administrators.

- 144.2(17) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

- 144.2(18) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action which arises out of the practice of the nursing home administrator **[NOTE: This provision only applies in circumstances where the administrator is specifically named in a lawsuit as a separate party, apart from the nursing facility].**

- 144.2(25) Failure to report another licensee to the board for any suspected violations listed in these rules **[NOTE: The regulations impose an affirmative duty on an administrator to report to the Board any knowledge of a fellow administrator's violation of standards applicable to Administrators].**

- 144.2(26) Knowingly aiding, assisting, or advising a person to unlawfully practice as a nursing home administrator.

- 144.2(27) Failure to report a change of name or address within 30 days after it occurs. Name and address changes may be reported on the form provided by the board at www.idph.state.ia.us/licensure.

- 144.2(30) Permitting an unlicensed employee or person under the licensee's control to perform activities that require a license.

- 144.2(31) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but is not limited to, the following:

  a. Verbally or physically abusing a patient, client or coworker.
  b. Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.
  c. Betrayal of a professional confidence. A licensee shall not disclose professional or personal information regarding recipients of service to unauthorized personnel unless required by law or to protect the public welfare.
  d. Engaging in a professional conflict of interest.
  e. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
  f. Being adjudged mentally incompetent by a court of competent jurisdiction.

- 144.2(32) Repeated failure to comply with universal precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

DISCIPLINARY ACTION SUMMARY - IOWA BOARD OF NURSING HOME ADMINISTRATORS

A review of past disciplinary actions includes some instructive examples. A majority of these disciplinary actions relate to DIA survey findings., often nursing deficiencies. In addition, many of these disciplinary actions related to resident-to-resident abuse including sexual assaults. https://idph.iowa.gov/Licensure/Iowa-Board-of-Nursing-Home-Administrators/Discipline-and-Public-Actions

I. Violation of a regulation which relates to the practice of nursing home administrators – administrator must work full time/knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of nursing home administration or engaging in unethical conduct or practice harmful or detrimental to the public/negligence by the licensee in the practice of the profession, which includes improper delegation of duties of supervision.

The Board alleged that the Administrator was not present or otherwise providing Administrator services for the facility for the amount of time required by Iowa Administrative Code (full time). The Board further allege alleged that the Administrator made misleading and untrue representations to staff and his employees that his license permitted this, and that while employed as Administrator, he permitted a person without a current license to engage in actions for which a current license is

required. **[NOTE: a reminder that the rules under 58.8(7) require that an administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. Administrators who oversee two facilities pursuant to 58.8(2), are required to spend the equivalent of three full eight-hour days per week in each facility].**

II. Unethical Conduct/Violation of a regulation which relates to the practice of nursing home administrators

Allegation was that Board received multiple complaints from multiple facilities where the administrator had worked that he/she was verbally abusive towards residents and staff and used overly aggressive bill collection tactics.

III. Practice harmful or detrimental to the public/ unethical conduct/violation of a regulation which relates to the practice of nursing home administrators.

The Board alleged that over a five-year period, two facilities under the administrator's ownership were cited with seven citations totaling $70,000. The Board has also received information that the Administrator lost his temper in front of the residents and treated his staff poorly. An additional allegation stated that the Administrator allegedly offered a surveyor alcohol during a site visit. The Administrator had already sold his buildings and moved out of state, and voluntarily surrendered his license to resolve the charges.

IV. Professional incompetence/negligence in the practice of the profession/violation of a regulation which relates to the practice of nursing home administrators.

The Board alleged that the Facility lacked adequate policies and procedures regarding incident reports, physician and family notifications regarding residents, investigating allegations of resident abuse, and handling incidents of resident-on-resident abuse. The facility failed on multiple occasions to respond to resident-on-resident sexual encounters (one resident accused of sexually accosting five different residents). The incidents were not properly reported to DIA, family or physicians and the accosted residents were denied proper care after the sexual assaults

V. Professional Incompetence.

The Board alleged that a male resident of the Facility sexually assaulted a female resident, and that the Administrator knew or should have known the male resident posed a threat to other residents. The Board alleged that the Administrator failed to ensure that all residents were protected from the known threat posed by the male resident.

VI. Professional incompetence/negligence in the practice of the profession/violation of a regulation which relates to the practice of nursing home administrators.

The Board asserted that there multiple examples non-compliance with applicable regulations including failures to adequately assess residents' needs and provide proper care, inadequate staff response to a resident elopement, failure to implement a care plan addressing sexually inappropriate behavior by a resident, failure to follow family notification requirements, failure to report elopement to DIA, failure to maintain incident record reports, failure to maintain policies and procedures in place addressing resident-on-resident abuse, and failure to report such abuse.

VII. Conviction of a crime relating to professions/engaging in practice harmful or detrimental to the public

The Board alleged that there was an altercation between the administrator and members of an ambulance crew which felt intimidated and threatened during this incident. Several witnesses to the incident report that Administrator used profanity and assumed a fighting stance. As a result of this incident, the administrator was charged with simple misdemeanor assault. The charge was amended, and administrator pled guilty to disorderly conduct.

VIII. Professional incompetence,

The Board alleged that the Administrator knowingly hired a director of nursing for the facility whose nursing license was under sanction and failed to implement proper safeguards in light of the sanction, and further failed to assure proper policies for safekeeping and handling of medications in the facility were in place and followed. Finally, the Board alleged that the Administrator failed to report significant medication discrepancies to the facility's consulting pharmacist.

IX. Negligence in the practice of the profession - failure "to exercise due care including improper... supervision of employees or other individuals.

The Board asserted that the administrator was in charge during a period of time when there were numerous serious nursing deficiencies including immediate jeopardy regarding lack of nursing assessments with serious outcome to a resident. The matter was resolved with the Administrator voluntarily surrendering her license.

Administrative Decision Relating to Disciplinary Charges:

Only one disciplinary charge has been taken to a formal administrative hearing in the past ten years. The Administrator was charged with professional incompetence, negligence in the practice of the profession and violation of a regulation which relates to the practice of nursing home administrators regarding allegations that two residents with dementia diagnoses were discovered engaging in sexual contact on two occasions.

The specific charges derived from survey findings including a determination of immediate jeopardy. The Board asserted that neither incident was handled consistently with facility policy and procedures regarding alleged abuse reporting and investigations, neither incident was reported to DIA as dependent adult abuse, the Facility's Director of Nursing had actively falsified resident records regarding one of the incidents, there was inadequate documentation of the incidents, the DON warned staff not to report the Incidents to DIA, there was inadequate supervision of the residents, staff had inadequate training, and that one of the residents was abruptly involuntarily discharged without following the notice requirements.

Following a hearing with presentation of multiple witnesses, the Board dismissed the counts relating with professional incompetence and negligence in the practice of the profession, but sustained a minor finding relating to charge regarding violation of a regulation, that the Administrator had involuntarily discharged one of the residents from the facility without providing proper written notice of the reason for the discharge and without providing notification of the right to appeal. The Administrator was fined $75.00.