IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

June 30, 2008

Complaint #17623

Nichole Will, Director
Country House
900 W 46th Street
Davenport, IA 52806-4362

RE: Complaint Investigation Report, Country House, Davenport, IA

Dear Ms. Will:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated April 28, 2008. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Report

Assisted Living Program:

Complaint Intake #: 17623

Jennifer Christenson, RN, MNHP, Director
Country House
900 W 46th Street
Davenport, IA 52806-4362

Date of Investigation:

April 28, 2008

Monitor(s):

Stephanie Cummins, SW MA

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Country House on April 28, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	27
Current number of tenants without cognitive disorder:	1
Total Population:	28

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There were substantiated complaints this certification period in the areas of: Medications, Nurse Review, Life Safety and Staffing.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

Complaint Allegation: It was alleged Tenant #1, had bruising on his/her arms from an unidentified staff member. It was alleged there was a lapse of 34 hours between the incident and the tenant being assessed by the nurse for injuries.

Monitoring Observation: Tenant #1, an 80 year old, was admitted on 1-29-08 with a diagnosis of Alzheimer's Disease. The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive impairment. Staff #2 alleged in her statement, on 3-25-08 at approximately 10:55 p.m., Staff #1 pulled Tenant #1's legs and grabbed the tenant by the left arm. An incident report dated 3-26-08 (p.m.) indicated the tenant had bruising on the right arm. The Director documented on an incident report that she assessed the bruises to the tenant's right upper forearm on 3-27-08 at 9:15 a.m. The note indicated there were three circular bruises, three centimeters in diameter. The tenant denied pain. Nurse review was not completed, as needed.

- Regulatory Insufficiency: The program did not assess and document the health status of a tenant, as needed, with a change in condition. (25.30(3))

B. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It was alleged Tenant #1 had bruising on his/her arm from an unidentified staff member. The date of the incident was 3-25-08. It was alleged there was no protocol for an incident narrative to be completed by staff. It was alleged the accident/incident report was dated 3-26-08, even though the date of the incident was 3-25-08.

Monitoring Observation: Staff #2 provided a statement and was interviewed. According to Staff #2, on 3-25-08 at 10:55 p.m., Tenant #1 was sleeping on the couch in the great room. Staff #1 asked Staff #3 to assist her with Tenant #1. Staff #1 did not wait for Staff #3 and pulled the tenant's legs and grabbed the tenant by the left arm. Staff #1 and Staff #3 then "drag" the tenant to his/her apartment, according to Staff #2.

Staff #1 provided a statement and was interviewed. Staff #1 indicated she asked someone to assist her putting Tenant #1 into bed and Staff #3 stated she would assist. Staff #1 stated she took off the middle cushion of the couch because the tenant's feet were underneath the cushion. Staff #1 turned the tenant's body to put his/her feet on the floor. Staff #1 was on the right side and Staff #3 was on the left side of the tenant as they stood the tenant up. The staff corrected in the statement that she was on the left side and she had her right hand in the middle of the tenant's back and took the tenant to his/her room. Staff placed the tenant in his/her bed, according to Staff #1.

Staff #3 provided a statement and was interviewed. Staff #3 indicated Staff #1 asked her to assist with Tenant #1. Staff #3 stated she was on the right side of the tenant with one hand under the tenant's arm pit and the other hand on the tenant's wrist. She stated Staff #1 was on the tenant's left side with her hands placed in the same position as hers. Staff #3 did not feel there was any roughness towards the tenant from either Staff #1 or herself.

On 3-26-08, when Staff #2 verbally reported the alleged incident, there was no written documentation of the alleged incident. According to the Director, Abuse/Neglect reports have been available in the staff mailboxes since 3-28-08. Prior to the alleged event, the reports were located in the Director's office. A report was not completed when the alleged incident occurred on 3-25-08; however, one was completed on 3-26-08. The incident report pertained to the tenant's bruising and not the alleged incident of 3-25-08.

Staff #2 stated she reported the alleged incident to Staff #4 at approximately 3:30 p.m. on 3-26-08 and Staff #4 reported it to the Director. On 3-26-08 when Staff #2 verbally reported the alleged incident, there was no written documentation of alleged incident turned in, according to the Director. According to the Director, the incident was reported by Staff #2 on 3-26-08 at 7:00 p.m. The Director indicated on 3-26-08 at 7:15 p.m., she visited with the tenant and the tenant had no complaints of pain or recollection of any abusive incidents and no change in condition was reported in the 24 hour reports by staff. According to an incident report dated 3-26-08 p.m., Staff #2 noticed bruises on the tenant's right arm. The Director indicated on the incident report that she assessed the bruised to right upper forearm on 3-27-08 at 9:15 a.m. The note indicated three circular bruises, three centimeters in diameter. The tenant denied pain and the tenant's physician and spouse were notified.

The Director reported the alleged incident to the Department of Human Services (DHS). Staff #1 came into the program and provided a statement on 3-27-08 and was told she was suspended until further investigation from Iowa Department of Human Services. On 3-28-08, the DHS investigator reported to the Director the alleged incident was not founded. Staff #1 returned to work on 4-1-08.

Staff #1, Staff #2 and Staff #3 had documented mandatory dependent adult abuse training.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet the tenants' identified needs. (25.33(1))

Dated this 30th day of June, 2008.