IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

August 25, 2008

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

RE: I. Final Incident Investigation Report
II. Civil Penalty
III. Conclusion

Dear Ms. Will:

I. Final Incident Investigation Report – Country House, Davenport, IA

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. The Final Report notes the **Regulatory Insufficiencies,** as defined in the areas of: Evaluation of Tenant, Service Plan, Nurse Review, Staffing, Record Checks and Other.

DIA is accepting the program's Plan of Correction (POC).

II. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Incident Investigation Report the civil penalty obligation, in the amount of five hundred ($500.00) dollars, is required.

III. Conclusion

Country House's Plan of Correction is accepted. A civil penalty of $500.00 is assessed.

DIA may revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to these matters, please contact me at (515) 281-5077.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 18367-I**

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

Date of Incident Investigation:

June 25, 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 an Incident 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:

An on-site visit was conducted at Country House on June 25, 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:	26
Current number of tenants without cognitive disorder:	2
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 no substantiated Regulatory Insufficiencies this certification period, beginning June 30, 2008.

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

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Four tenant files were reviewed.

Tenant #2, a 74 year old, was admitted on 8-1-06 and diagnoses include: Dementia, Hypertension (HTN), Anxiety, Recent MRSA Infection and Left Hip Pain. The tenant was staged at a seven on the GDS, which indicated very severe cognitive impairment. The tenant was identified in a self reported incident, which alleged abuse. According to nurse's notes dated 6-12-08 at 1125, the tenant was assessed for signs and symptoms of abuse or neglect. No apparent injuries or complaints of abuse were noted. Evaluations were completed on 6-23-08. Nurse's notes from 5-7-08 to 5-28-08 discussed the tenant's need for a two person assist with transfer (tenant no longer was a two person assist at the time of this investigation), bruising to the left hip and ankles, skin abrasions and the start of Physical Therapy (PT). Evaluations were not completed, as needed, with change in condition.

Tenant #4, an 84 year old, was admitted on 3-30-05 with a diagnosis of Alzheimer's Disease. The tenant was staged at a seven on the GDS, which indicated very severe cognitive impairment. The tenant was discharged on 6-19-08. The tenant was identified in a self reported incident, which alleged abuse. Nurse's notes dated 6-12-08 at 1140, indicated the tenant was assessed and the tenant's overall skin condition was poor with random bruising and breakdown. According to the notes, there was nothing out of the ordinary. The tenant was unable to report any bruises or neglect. The service plan was updated on 5-7-08, 5-27-08, 5-30-08, 6-6-08 and 6-11-08. Evaluations were not completed at all of those intervals. For example, the cognitive evaluation was completed on 5-4-08 and on 6-11-08. The functional evaluation was completed on 5-2-08 and on 6-11-08. The service plan was updated at these intervals to reflect increased services and needs including: total care for activities of daily living, the inability to ambulate, taking two staff for maximum assistance, and was started on Hospice. Evaluations were not consistently completed, as needed, with a change in condition.

- Regulatory Insufficiency: The program did not consistently evaluate each tenants' functional, cognitive and health status as needed to determine the tenants' continued eligibility for the program and to determine any modifications to the services needed. (25.23(2))

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Four tenant files were reviewed.

Tenant #2 was identified in a self reported incident, which alleged abuse. According to nurse's notes dated 6-12-08 at 1125, the tenant was assessed for signs and symptoms of abuse or neglect. No apparent injuries or complaints of abuse were noted. Nurse's notes from 5-7-08 to 5-28-08 discuss the tenant's need for a two person assistance with transfers (tenant is no longer a two person assist at the time of this investigation), bruising to the left hip and ankles, skin abrasions and the start of PT. The service plan was not updated, as needed, and did not reflect the current and identified needs of the tenant.

Tenant #4 was identified in a self reported incident, which alleged abuse. Nurse's notes dated 6-12-08 at 1140 indicated the tenant was assessed and the tenant's overall skin condition was poor with random bruising and breakdown. According to the notes, there was nothing out of the ordinary. The tenant was unable to report any bruises or neglect. The service plan was updated on 5-7-08, 5-27-08, 5-30-08, 6-6-08 and 6-11-08. Evaluations were not completed at all of those intervals. For example, the cognitive evaluation was completed on 5-4-08 and on 6-11-08. The functional evaluation was completed on 5-2-08 and on 6-11-08. The service plan was updated at these intervals to reflect increased services and needs including: total care for activities of daily living, the inability to ambulate, taking two staff for maximum assistance, and was started on Hospice. The service plan was not based on evaluations.

- Regulatory Insufficiency: The program did not consistently develop service plans for tenants, as needed, when a tenant needs personal care or health-related care. (25.28(3))

- Regulatory Insufficiency: The program did not consistently develop service plans that meet the identified needs of the tenants (25.28 (4a))

C. 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]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Four tenant files were reviewed.

Tenant #1, an 80 year old, was admitted on 1-29-08 and diagnoses include: Alzheimer's Disease. The tenant was staged at a 6.6 on the Global Deterioration Scale (GDS), which indicates moderately severe cognitive impairment. Tenant #1 was identified in a self reported incident, which alleged abuse. According to nurse's notes dated 6-12-08 at 1115, the tenant was assessed for signs and symptoms of abuse or neglect. No apparent injuries or complaints of abuse were noted. Nurse review was completed on 6-23-08. A nurse review was not completed, as needed, as a result of the self reported incident.

Tenant #2 was identified in a self reported incident, which alleged abuse. According to nurse's notes dated 6-12-08 at 1125, the tenant was assessed for signs and symptoms of abuse or neglect. No apparent injuries or complaints of abuse were noted. Nurse review was completed on 6-23-08. Nurse's notes from 5-7-08 to 5-28-08 discuss the tenant's need for two person assistance with transfers (tenant no longer is a two person assistance at the time of this investigation), bruising to left hip and ankles, skin abrasions, and the

start of PT. Nurse review was not completed, as needed, as a result of the self reported incident.

Tenant #3, a 90 year old, was admitted on 10-7-05 and diagnoses include: Dementia, Degenerative Joint Disease (DJD) and HTN. The tenant was staged at a 5.6 on the GDS, which indicated moderately severe cognitive impairment. Tenant #3 was identified in a self reported incident, which alleged abuse. According to nurse's notes dated 6-12-08 at 1135, the tenant was assessed for signs and symptoms of abuse or neglect. No apparent injuries or unknown bruising were noted. The tenant was unable to report any abuse or neglect situation. Nurse review was completed on 6-23-08. Nurse review was not completed, as needed, as a result of the self reported incident.

Tenant #4 was identified in a self reported incident, which alleged abuse. Nurse's notes dated 6-12-08 at 1140, indicated the tenant was assessed and the tenant's overall skin condition was poor, with random bruising and breakdown. According to the notes, there was nothing out of the ordinary. The tenant was unable to report any bruises or neglect. A nurse review was not completed, as needed, as a result of the self reported incident. The service plan was updated on 5-7-08, 5-27-08, 5-30-08, 6-6-08 and 6-11-08. The service plan was updated at these intervals to reflect increased services and needs including: total care for activities of daily living, the inability to ambulate, taking two staff for maximum assistance, and was started on Hospice. Nurse review was not completed, as needed, with a change in condition.

- Regulatory Insufficiency: The program did not consistently assess and document the health status of each tenant and make recommendations at least every 90 days or if there are changes in health status. (25.30(3))

D. 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]

Incident Allegation: It was alleged Staff #2 saw Staff #1 sit on tenants to make them stay on the toilet. It was alleged Staff #1 called the tenants names and said the tenants were "F***ing nasty." It was alleged Staff #1 held up her fists as though she was going to hit the tenants. It was alleged Staff #1 forcefully yanked things, such as dolls and blankets, away from the tenants.

Monitoring Observation: Review of staff files indicated Staff #1 had appropriate background checks completed prior to hire, had six hours of dementia training completed on 6-10-08 and had dependent adult abuse training completed on 4-28-08.

According to an Abuse/Neglect Report dated 6-12-08, the date, time and place of the incident were unknown, as it was a general complaint. The report identified Staff #1 as the caregiver and Tenants #1, #2, #3 and #4 as the tenants involved. The incidents were described as staff calling names, telling tenants they were "f" nasty, holding up a fist like she was going to hit tenants and yanking things away in a forceful manner. The report also indicated Staff #2 remembered Staff #1 saying to Tenant #4 "if you bite me or hit me I'll blacken your eye." The report indicated there was no evidence of abuse/neglect. Staff #1 was suspended pending the Department of Human Services (DHS) investigation. According to the report, the former Director talked to the first shift supervisor and other

day staff and there were no reports of anyone seeing abusive behavior, only reports of a negative attitude at work. Staff #1 commented that "these people gross me out." The report indicated DHS and the Department of Inspections and Appeals (DIA) were notified on 6-12-08.

Staff #2 was interviewed and stated nothing specifically happened on 6-12-08, the day of the report. The following incidents were things she had observed over the two to three weeks prior to 6-12-08. Staff #2 indicated she saw Staff #1 sit on Tenant #1 to keep him/her on the toilet. Staff #2 stated Staff #1 grabbed Tenant #1's arm, probably on the right side, during this incident. Staff #2 stated this occurred in the bathroom with a shower on the A hall. This was not witnessed by any other staff and the door to the bathroom was closed. There were no injuries to the tenant; however, the tenant asked Staff #2 to help him/her.

Staff #2 reported she was in the B hall dining room and came up to ask Tenant #3 what was wrong. Staff #1 responded "nothings wrong with that lazy bitch, she's just nasty," according to Staff #2. There were other tenants in the living area and no other staff present. Staff #2 stated the tenant did not have a reaction to the incident.

Staff #2 stated when Staff #1 was in the B hall bathroom, next to the kitchen, she raised her fist to Tenant #4 and said either she would break his/her nose or blacken his/her eye. Staff #2 witnessed this behavior. Staff #2 said Staff #1 would raise her fist to Tenant #1 and Tenant #4.

Staff #2 reported Staff #1 lunged at Tenant #1 with her fist in the air, in the B hall dining area. Staff #2 witnessed the behavior.

Staff #2 stated Staff #1 yanks the baby doll away from Tenant #2 and throws the baby doll. According to Staff #2, Tenant #2 thinks the baby doll is his/her son. Staff #2 could not remember if there were other staff around when this occurred. Staff #2 reported the tenant was upset and this happened twice, once in the A hall living area and once in the A hall bathroom.

Staff #2 indicated there was another incident she had forgotten to tell DHS. Staff #1 was trying to get Tenant #2 to go to the bathroom. Staff #1 put her arms around the tenant's chest restricting the tenant's arms at his/her side and moved the tenant very quickly from the living area to the bathroom. Staff #2 stated she witnessed this occurrence, as did Staff #3.

Staff #3 was interviewed. Staff #3 stated while she was watching training videos in the A hall small dining room, approximately the third week of April, she witnessed the following incident. Staff #1 wrapped her arms around Tenant #2 with the tenant's arms over the staff's arms, like a bear hug. Staff #3 indicated Staff #1 forced the tenant to move faster to the bathroom and man-handled the tenant and forced him/her down to the bathroom. Staff #3 stated the tenant made noise; however, does not talk a lot, but tried to fight it. Staff #3 did not remember who else was working at the time of the incident. Staff #3 reported she did not hear Staff #1 make any comments directly about Tenant #3; however, Staff #4 had heard Staff #1 make remarks about Tenant #3.

Staff #4 was interviewed and stated that approximately a month and a half ago, on first shift in the B hall, Tenant #3 was being combative and would not let Staff #1 clean him/her up. Staff #1 told Staff #4 she "couldn't F*** do it anymore." She stated she was not going to change Tenant #4 anymore and told Staff #4 to do it. Staff #4 stated to Staff #1 that they were here for a reason. Staff #1 also described Tenants #3 and #4 as "gross."

Staff #1 stated she or other staff had not been aggressive physically or verbally towards tenants. Staff #1 stated she or other staff had not forced tenants, including Tenant #1, to sit on the toilet. Staff #1 stated she or other staff had not used explicit language towards or yelled at a tenant, including Tenant #3. Staff #1 stated she or other staff had not held up a fist at a tenant in an aggressive way, including Tenants #1, #2, #3 or #4. Staff #1 stated she or other staff had not forcefully taken things away from tenants, including Tenant #2. Staff #1stated she or other staff did not rush Tenant #2 while taking him/her to the toilet. Staff #1 indicated Tenant #2 could not be rushed or he/she may fall because the tenant already leaned forward.

Staff files were reviewed and indicated Staff #2, #3 and #4 had appropriate dementia training and mandatory dependent adult abuse training.

According to a program document, the current Director (started as Director on 6-23-08) contacted the previous Director and she stated the families of the tenants involved in the alleged incidents were not made aware of the situation.

According to a program document dated 6-12-08, Staff #1 was contacted by the former Director, to inform her about the accusations and requested a statement concerning those accusations. Staff #1 was unable to come in to the office to provide a statement. Staff #1 denied all accusations and was notified she was suspended until further investigation from DHS. According to a program document, Staff #1 returned to work on 6-18-08.

Staff #1, #3 and #4 indicated staffing was not sufficient to meet the needs of the tenants. One family indicated there was not sufficient staff to meet the tenants' needs. Another family indicated the direct care staff were meeting the care needs; however, stated a supervisor was needed in each building for first shift.

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

E. Record Checks – The program conducts applicable employee record checks. [Iowa Code section 135C.33(5)]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Staff #2 was hired on 4-8-08 and did not have appropriate background checks completed prior to hire. A criminal history check and dependent adult abuse check were completed on 6-25-08, the day of the on-site.

- Regulatory Insufficiency: The program did not consistently complete a Department of Public Safety, criminal history check and a Department of Human Services, dependent adult abuse check of the potential employee, prior to hire. (135C.33(1))

F. Other - The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

Monitoring Observation: Staff #2 indicated there was another incident she had forgotten to tell DHS. Staff #1 was trying to get Tenant #2 to go to the bathroom. Staff #1 put her arms around the tenant's chest restricting the tenant's arms at his/her side and moved the tenant very quickly from the living area to the bathroom. Staff #2 stated she witnessed this occurrence, as did Staff #3.

Staff #3 was interviewed. Staff #3 stated while she was watching training videos in the A hall small dining room, approximately the third week of April, she witnessed the following incident. Staff #1 wrapped her arms around Tenant #2 with the tenant's arms over the staff's arms, like a bear hug. Staff #3 indicated Staff #1 forced the tenant to move faster to the bathroom and man-handled the tenant and forced him/her down to the bathroom. Staff #3 stated the tenant made noise; however, does not talk a lot, but tried to fight it. Staff #3 did not remember who else was working at the time of the incident. Staff #3 reported she did not hear Staff #1 make any comments directly about Tenant #3; however, Staff #4 had heard Staff #1 make remarks about Tenant #3.

Staff #4 was interviewed and stated that approximately a month and a half ago, on first shift in the B hall, Tenant #3 was being combative and would not let Staff #1 clean him/her up. Staff #1 told Staff #4 she "couldn't F*** do it anymore." She stated she was not going to change Tenant #4 anymore and told Staff #4 to do it. Staff #4 stated to Staff #1 that they were here for a reason. Staff #1 also described Tenants #3 and #4 as "gross."

- Regulatory Insufficiency: The program did not establish and maintain a safe and homelike environment for individuals of all income levels who require assistance to live independently but who do not require health-related care on a continuous twenty – four hour per day basis. (231C.1(2)a)

Dated this 26th day of August, 2008.