IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 35804-C

December 9, 2011

Ms. Kylie Behm-Newhard, Manager
Waterford Assisted Living
1325 Coconino Road
Ames, IA 50010

RE: Final Complaint/Incident Investigation Report – Waterford Assisted Living, Ames, IA

Dear Ms. Newhard:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 13, 2011, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint/Incident Intake: #35804-C**

Kylie Behm-Newhard
Waterford Assisted Living
1325 Coconino Road
Ames, IA 50010

Date of Complaint/Incident Investigation:

September 13, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

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:	48
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	49
TOTAL census of Assisted Living Program	49

Program History – The program did not receive any regulatory insufficiencies during this certification period.

A. Other

Complaint/Incident Allegation: It was alleged a tenant was asleep in bed at 2:00 a.m. on 9-8-11, when an unknown man got into the tenant's bed and put his hand into the tenant's underwear. The tenant told the man to get out and went into the living room to get away from the man. The man left the apartment. Staff approached the tenant and the tenant reported the incident.

Monitoring Observation: Tenant #1 (the Tenant), an 81 year old, was admitted on 7-29-11 and had diagnoses of: Alzheimer's Dementia, Atrial Fibrillation, Osteoporosis, History of Pacemaker Placement, Depression, History of Atrial Ablation, History of Hysterectomy, Osteoarthritis, Renal Stasis with Chronic Leg Ulceration and Congestive Heart Failure. A Global Deterioration Scale (GDS) was completed on 8-24-11 and staged the tenant at three, which indicated mild cognitive impairment. A service plan of 8-29-11 indicated the Tenant needed assistance with activities of daily living (ADLs), including bathing, grooming, dressing, and toileting and was administered medication by the program. The Tenant wore a wander-guard device, as the Tenant had a history of wandering and confusion. The service plan indicated safety interventions, including the Tenant's preference for the use of an emergency pendent and twice nightly checks. Program documentation indicated hourly checks were completed since admission. Hour check sheets were randomly checked prior to and after the incident of 9-7-11 and indicated staff consistently completed one-hour checks on the Tenant.

Nurse's notes of 9-8-11 at 1:55 a.m., indicated staff was sitting in the first floor south nurse's station when they heard a door open on the first floor south corridor and immediately investigated. Staff found the Tenant's door open and the Tenant was "wandering" around the living room. The Tenant told staff a man had just been in his/her room. The tenant was in bed and a man came in and sat on the bed. The Tenant told the man he/she was married and the man then left. Staff assisted the Tenant by looking throughout the Tenant's apartment to reassure the Tenant no one was in the apartment. Staff assisted the Tenant back to bed and told the Tenant to use his/her pendent and call for assistance. Staff reported they never saw anyone or heard

anyone in the hallway and door alarms did not activate that night. Nurse's notes of 9-13-11, corrected the date of the incident of 9-8-11 to 9-7-11.

Two incident reports of 9-7-11 were completed by Staff #1 and Staff #2. Staff #1 reported she and Staff #2 were working 10:00 p.m. to 6:00 a.m. on 9-7-11. She and Staff #2 had been sitting in the medication room (nurse's station), for about 30-minutes. At 1:55 a.m. they both heard a door open in the hallway. Both staff went and looked to see whose door it was and found the Tenant's door "cracked open." Staff entered the apartment and found the Tenant wandering in the living room. Staff asked the Tenant was he/she was doing and were told a man had been in the room. The Tenant said a man came in and sat on the bed. The Tenant told the man he/she was married and the man left. Staff proceeded to look in the Tenant's closets and reassured the Tenant no one was in the apartment. Staff assisted the Tenant back to bed and directed the Tenant to use his/her pendent if needed and staff would "be there right away." Staff left and locked the door to the apartment.

Staff #1 and Staff #2 were interviewed and each reported two staff usually worked the night shift. Neither staff identified any tenants who had been physically or sexually harmed. Staff #1 and Staff #2 identified Tenant #1 and another female tenant who received one-hour safety checks and wore wander-guard bracelets. Staff #1 confirmed the incident of 9-7-11 and reported at approximately 1:00 a.m. she was assisting another tenant for about 30-minutes and went to the staff medication room (nurse's station). She and Staff #2 were in the nurse's station for about 30-minutes, when at approximately 1:50 a.m. they heard a tenant's apartment door open. Both staff investigated and found the Tenant's door ajar about two inches. She stated the Tenant's apartment was checked one-hour earlier as part of the Tenant's one-hour safety checks and it was noted the Tenant's door was locked. She stated the Tenant was found wandering around her living room. Staff asked the Tenant what he/she was doing. The Tenant said a man had come into his/her apartment and sat on the bed next to where he/she was laying. The Tenant said he/she was married. The man got up and left her apartment. Staff checked the apartment, including the closets and bathroom and no one was present. Staff assisted the Tenant back to bed and told the Tenant to use his/her pendent if he/she needed assistance. Staff left the apartment and locked the door to the apartment.

Staff #1 stated the Tenant locked the apartment door at night and goes to bed before night shift arrives. She stated she did not hear any screaming or anyone speaking loudly. The Tenant did not wander at night and had no behavior or verbal statements of delusional thought. She stated there were no tenants who wandered at night and only one female tenant who wandered, but not at night. She stated one hour safety checks were done since admission and staff always checked the Tenant's door to make certain it is locked.

Staff #2 was interviewed and confirmed the incident of 9-7-11. She stated the incident occurred at 1:55 a.m. because she had looked at the clock after hearing a tenant's door open. She had been in the medication room (nurse's station) since 1:00 a.m. as she was taking a break from cleaning and another tenant's apartment. She and Staff #1 went down the hallway and noticed the Tenant's apartment door was open. She stated the Tenant had all the lights on and said he/she was looking for something. She stated the Tenant said someone was in his/her room. She opened the Tenant's

bedroom door and noted the bathroom door was closed. The Tenant said "he must have gone through there." Staff opened the bathroom door and no one was found. The Tenant said "he must have gone through there," pointing to the closet. She opened the closet door and showed the Tenant the closet. The Tenant said he/she told the man he/she was with someone and "he said okay and left." The Tenant paced the room and staff asked if he/she was okay. She helped the Tenant back to bed and noticed the Tenant was wearing an incontinent undergarment. She stated one-hour safety checks had been completed since admission. She stated staff would unlock the Tenant's door, visually check the tenant, leave and lock the Tenant's door. She stated there were no male tenants who wandered and no male tenants had made sexual gestures toward staff or tenants. She stated the Tenant's bed covers were neat and one side was folded over as if someone got out bed. The Tenant's windows were closed.

Nurse's notes of 9-9-11, indicated the Tenant came to the front office and reported a man had been in his/her room at night. The Tenant couldn't remember which night, but stated a man had tried to get into the Tenant's bed. The Tenant told him he/she had not had sex before marriage and "not after either and the man then got up and left." The Tenant stated several times someone had told him/her to tell someone.

Nurse's notes of 9-11-11, indicated Staff #3 was administering medications to the Tenant, the Tenant approached her and stated "I was violated sexually by an unknown gentleman who entered my room 2 nights prior." The Tenant reported the gentleman was trying to rape him/her. The Tenant began to scream and the man held his hand over his/her mouth and said if he/she continued to scream he would hurt his/her family. The Tenant reported he/she told them and he/she had only been with one man and that was his/her spouse. The Tenant reported "after the unknown gentleman had his way with," him/her, he left his/her bed and quietly left through the front door. The tenant stated he/ she stayed in bed because he/she was frightened. The Tenant reported he/she must have fallen asleep, because the next thing he/she knew was staff waking him/her for breakfast. Staff #3 completed an incident report and reported this event and notified the Program Nurse.

An incident report was completed by Staff #3 related to the incident of 9-11-11. She reported she went into the Tenant's apartment to administer medications and was told, by the Tenant; he/she had been violated sexually by an unknown gentleman that entered his/her apartment two nights prior. The gentleman tried to rape him/her and he/she began to scream and he held his hand over his/her mouth and told the Tenant if he/she continued to scream he would hurt the Tenant's family. After the unknown gentleman had his way with him/her, had told him she/he had only been with his/her spouse.

Staff #3 was interviewed and did not identify any tenants who had been physically or sexually harmed by a tenant or staff. She identified two tenants, Tenant #1 and another tenant, as having one-hour safety checks and each wore a wander-guard bracelet. She confirmed what had been reported in the incident report and had reported the incident to the Program Nurse. She stated the Tenant was on routine one-hour checks and the Tenant's door is locked. Staff knock on the Tenant's door; wait for an answer from the Tenant and the Tenant would unlock the door. Staff lock the door when the leave the Tenant's apartment.

On 9-11-11, the Tenant's family spoke to the Administrator and reported the Tenant had been sexually assaulted. The Administrator spoke to the Tenant's family and spoke to the Program Nurse. The Program Nurse spoke to the Tenant's family and reported she believed the Tenant had a "dream/hallucination/delusion." The Tenant's family requested she call the police and DIA. The Program Nurse told family she would call the police. The Program Nurse spoke to the Administrator and was informed the police had been called. Police records indicated a police officer arrived at the program at 7:57 p.m. A police officer interviewed the Tenant and the Tenant reported he/she didn't believe the apartment door or bedroom door was locked. The Tenant reported someone got into his/her residence and got into bed on the opposite side of where he/she was lying and began to fondle him/her. The Tenant reported he/she was shaken up and he/she told the suspect he/she had a spouse but the spouse was not there and had passed away. The Tenant reported getting out of bed, walked to a chair in the living room and sat down. The Tenant reported the suspect "must have gotten out." The Tenant got up and went to the door, looked in the hallway to see if anyone was there and found no one. Police records indicated the initial report would be forwarded onto detectives.

On 9-13-11, a monitor contacted the police officer who first investigated this incident. The monitor was referred to a police detective. A police report was obtained at that time. Local police detective reported the Tenant's nightgowns and two pillow cases were to best tested for the presence of blood or seminal fluid. On 12-1-11 testing found no presence of blood or seminal fluid on the nightgowns or pillow cases.

- Regulatory Insufficiency: None noted.