IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 37095-I

January 24, 2012

Ms. Sally Hill, Director of Memory Care
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint/Incident Investigation Report, Senior Star at Elmore Place Memory Care, Davenport, Iowa

Dear Ms. Hill:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Sally Hill, Director of Memory Care
Senior Star at Elmore Place Memory Care
4504 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 37095-I

Date of Complaint/Incident Investigation:

December 20, 21, 22 & 29, 2011 and January 3, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	18
Total Population of Program at time of on-site	20
TOTAL census of Assisted Living Program	20

Program History – The program received Regulatory Insufficiencies in the area of Dementia Specific Education during this certification period.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Policies and Procedures

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

- Monitoring Observation: Tenant #1, a 62 year old, was admitted on 6-9-11 and diagnoses include Multiple Sclerosis and Front Lobe Dementia. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  Tenant #2, an 85 year old, was admitted on 10-8-10 and diagnoses include Coronary Artery Disease, Cerebral Vascular Accident, Dementia, Depression and Gastro Esophageal Reflux Disease. Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #2 moved out on 12-23-11.

  According to a Program record, on 12-13-11 at 3:15 a.m. staff heard Tenant #1 yelling and they responded immediately to Tenant #1's apartment. They found Tenant #2 in Tenant #1's apartment sitting at the end of Tenant #1's bed. Tenant #2 was caressing Tenant #1's left thigh, tugging at Tenant #1's protective undergarment; however, the protective undergarment was still pulled up. Tenant #1 was wearing what he/she wore to bed and Tenant #2 was fully clothed. The third shift nurse found no injuries or physical evidence of sexual abuse. Staff immediately redirected Tenant #2 from Tenant #1's apartment but were met with resistance and they had to take Tenant #2's arm and escort him/her out of Tenant #1's apartment. Staff #1 asked Tenant #2 why he/she was in Tenant #1's apartment and Tenant #2 said "I want sex."

Immediately after taking Tenant #2 to his/her apartment, all of the tenants' doors were closed and locked; however, the doors never locked from the inside so tenants always had the ability to open their door. Staff checked on Tenant #2, 15 minutes after he/she was escorted to his/her apartment and found Tenant #2 attempting to pull open the locked doors to other tenants' apartments. Staff requested Tenant #2 return to his/her apartment and Tenant #2 did so without altercation and remained in the apartment the remainder of the shift. Tenant #2's legal representative was notified of the incident and was informed of regulations and the Program's involuntary discharge policy as described in the occupancy agreement.

According to the Incident Report Policy, the responsible person was an employee who witnesses or responded to an incident. The responsible person was to report any potential liability incident involving a resident, guest, employee, company vehicle or company property. Completion of the proper incident report form was expected and would be given to a supervisor immediately. Incidents to be reported included allegations of assault or abuse.

At the time of the investigation, the Program provided incident reports related to the incident; however, the reports were not completed at the time of the incident.

The Program did not complete incident reports for the incident between Tenant #1 and #2 at the time of the incident on 12-13-11. The Program did not follow the Incident Report Policy.

- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum, shall include the following: All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67.2(1)(e))

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

- Monitoring Observation: Tenant #1 and Tenant #2 had visual checks completed on third shift on 12-13-11. Checks were consistently completed at the time of the incident. Checks were not consistently documented as completed throughout the month of December 2011 on all shifts for Tenant #1 and Tenant #2.

  According to the Staffing Policy, the Program did not provide one to one care. The Program would have one or more staff persons who monitored tenants. The staff should be awake and on duty 24 hours a day in the proximate area and check on tenants. If, for some reason, a tenant was unable to use the response system, or the system was down, staff would check on each tenant a minimum of every 60 minutes within the Memory Care building, or more often as indicated by the tenant care plan.

  Checks were not consistently documented as completed throughout the month of December 2011 on all shifts for Tenant #1 and Tenant #2. The Program did not follow the Staffing Policy related to tenant checks.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

B. Criteria for Admission and Retention

Complaint/Incident Allegation: The Program reported there was inappropriate touching from one tenant to another tenant. The Program reported no injury occurred to the tenant and no history of inappropriate touching.

- Monitoring Observation: According to a Program record, on 12-13-11 at 3:15 a.m. staff heard Tenant #1 yelling and they responded immediately to Tenant #1's apartment. They found Tenant #2 in Tenant #1's apartment sitting at the end of Tenant #1's bed and Tenant #2 was caressing Tenant #1's left thigh, tugging at Tenant #1's protective undergarment; however, the protective undergarment was still pulled up. Tenant #1 was wearing what he/she wore to bed and Tenant #2 was fully clothed. The third shift nurse found no injuries or physical evidence of sexual abuse. Staff immediately redirected Tenant #2 from Tenant #1's apartment but were met with resistance and they had to take Tenant #2's arm and escort him/her out of Tenant #1's apartment. Staff #1 asked Tenant #2 why he/she was in Tenant #1's apartment and Tenant #2 said "I want sex." Immediately after taking Tenant #2 to his/her apartment, all of the tenants' doors were closed and locked; however, the doors never locked from the inside so tenants always had the ability to open their door. Staff checked on Tenant #2, 15 minutes after he/she was escorted to his/her apartment and found Tenant #2 attempting to pull open the locked doors to other tenants' apartments. Staff requested Tenant #2 return to his/her apartment and Tenant #2 did so without altercation and remained in the apartment the remainder of the shift. Tenant #2's legal representative was notified of the incident and was informed of regulations and the Program's involuntary discharge policy as described in the occupancy agreement. Tenant #2's legal representative was responsible to ensure Tenant #2 received one to one staffing when needed and at least during the night until Tenant #2 was discharged. Tenant #2's legal representative was given names of staffing agencies and long term care facilities. The involuntary discharged process was initiated per the occupancy agreement and regulations. Tenant #2 did not have a past history of any aggressive sexual behaviors and Tenant #1 did not have any known past history of sexual abuse.

  Tenant #1's file was reviewed. According to the Nurse's Notes dated 12-13-11 at 4:00 p.m., the Assistant Director of Memory Care documented Tenant #1's family member was notified of the incident that occurred regarding Tenant #2 who entered Tenant #1's apartment.

  She informed the family member Tenant #2 was fully dressed, stroking Tenant #1's leg and attempting to pull down the protective undergarments. The family member appreciated being notified and that the Program had locked Tenant #1's door and completed frequent checks.

Tenant #2's file was reviewed. Cognitive, health and functional evaluations were completed after the incident. A service plan was developed after the incident and reflected the addition of one to one staffing every night until discharge. According to a Program document, Tenant #2's neurologist and nurse practitioner were notified of the incident and no new orders were received. Prior to the incident Tenant #2 was staged at five on the GDS, which indicated moderately severe cognitive decline. After the incident Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. The service plan prior to the incident did not reflect any issues or previous history with inappropriate sexual behavior towards tenants. The service plan updated after the incident reflected the episode in regards to the behavior. Review of Tenant #2's file indicated he/she did not have a history of sexual behaviors towards tenants. According to a letter to Tenant #2's legal representative Tenant #2 was to move out as soon as possible, by 12-29-11. The letter indicated Tenant #2's neurologist and nurse practitioner felt the behaviors were a progression of the disease and that no medication could guarantee that the sexual aggression would not occur again. The letter also reiterated one to one supervision at night was required until Tenant #2 was discharged to provide safety to the other tenants. The letter provided phone numbers of two long term care facilities and assistance with the process was offered by the Program.

Staff #2 stated Tenant #1 had pushed the call button. When she walked into Tenant #1's apartment, she saw Tenant #2 sitting on Tenant #1's bed, rubbing Tenant #1's leg in a non-sexual way. She asked Tenant #1 if he/she was okay and Tenant #1 responded "Yes." Tenant #1 had been telling Tenant #2 to leave. Tenant #2 stated he/she just wanted to talk. Staff #2 informed Staff #1 of the incident. Staff #2 stated Tenant #2 was wearing pants, a shirt and hat. Tenant #1 was wearing a tee shirt and a protective undergarment. Staff #2 stated Tenant #2 was only touching Tenant #1's leg and was not touching the undergarment. Staff #2 stated Tenant #2 had walked past her ten minutes before the incident. Prior to that, Tenant #2 had been walking in the halls 30 to 35 minutes earlier.

Staff #1 stated Tenant #2 had been in the dining room and left to go to his/her apartment to use the bathroom. Shortly afterwards, approximately five to ten minutes later, she heard Tenant #1 yelling. When she arrived at Tenant #1's apartment, two caregivers had already responded and informed her of the details of the incident. She was told Tenant #2 was rubbing Tenant #1's leg and tugging on Tenant #1's undergarment. Tenant #2 had already left Tenant #1's apartment when she arrived at the apartment. She stated Tenant #2 was on 30 minute checks and was most recently seen five to ten minutes before the incident. Staff #1 stated she completed a head to toe assessment on Tenant #1 and there were no injuries or physical evidence of sexual abuse. She asked Tenant #1 how he/she was and Tenant #1 responded he/she was okay.

The Director of Memory Care stated she came to work early, about 8:00 a.m. on 12-13-11 and was told by a staff member that Tenant #2 was found in Tenant #1's apartment on the third shift and he/she told staff he/she wanted to have sex. She called Staff #2 and was told Tenant #1 was wearing a tee shirt and protective undergarment.

Tenant #2 was tugging at the undergarment and stroking the upper left thigh of Tenant #1. Tenant #2 was sitting on Tenant #1's bed. She was told staff shut all tenant doors after the incident.

Staff #1, Staff #2 and the Director of Memory Care stated Tenant #2 did not have any previous history of sexual behaviors towards any tenants. Staff #2 stated Tenant #2 made a comment to staff the night before that everyone needed sex. Staff #2 stated she did not feel Tenant #2 was a threat to other tenants, nor meant any harm to anyone.

After the incident occurred the Program separated Tenant #1 and Tenant #2 and ensured the safety of the other tenants. Tenant #1 did not have any injury and it was determined no sexual abuse had occurred. Tenant#1's family member was notified on the incident. Tenant #2 did not have a history of sexual behaviors towards tenants. The service plan was updated and reflected interventions related to the behavior. Tenant #2 was required to have one to one supervision at least during the night until he/she was discharged. The involuntary transfer process was initiated and Tenant #2 moved out on 12-23-11. The Program reported the incident to the Department.

- Regulatory Insufficiency: None noted.

C. Nurse Review

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

- Monitoring Observation: According to a Program record, on 12-13-11 at 3:15 a.m. staff heard Tenant #1 yelling and they responded immediately to the Tenant #1's apartment. They found Tenant #2 in Tenant #1's apartment sitting at the end of Tenant #1's bed and Tenant #2 was caressing Tenant #1's left thigh, tugging at Tenant #1's protective undergarment; however, the protective undergarment was still pulled up. Tenant #1 was wearing what he/she wore to bed and Tenant #2 was fully clothed. Staff #1 stated she completed a head to toe assessment on Tenant #1 and there were no injuries or physical evidence of sexual abuse. She asked Tenant #1 how he/she was and Tenant #1 responded he/she was okay. However the assessment was not documented at the time of the incident. A nurse review was not completed related to Tenant #1 at the time of the incident.

  According to the Nurse's Notes dated 12-13-11 at 4:00 p.m., the Assistant Director of Memory Care documented Tenant #1's family member was notified of the incident that occurred regarding Tenant #2 who entered Tenant #1's apartment. She informed the family member Tenant #2 was fully dressed, stroking Tenant #1's leg and attempting to pull down the protective undergarments. The family member appreciated being notified and that the Program had locked Tenant #1's door and completed frequent checks.

  At the time of the investigation the Program completed a nurse review for Tenant #1 regarding the incident; however, it was not completed at the time of the incident.

A nurse review was not completed as documented for Tenant #1 at the time of the incident. Nurse review was not completed as needed.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))