IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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Complaint/Incident Intake #: 38947-M

June 12, 2012

Ms. Katie Cummings, Housing Manager
Meadows Assisted Living
528 North Kelly Street
Shell Rock, IA 50670

RE: Final Complaint/Incident Investigation Report, Meadows Assisted Living, Shell Rock, Iowa

Dear Ms. Cummings:

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 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

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 #: 38947-M

Katie Cummings, Housing Manager
The Meadows Assisted Living
528 North Kelly Street
Shell Rock, IA 50670

Date of Complaint/Incident Investigation:

May 8th and 9th, 2012

Monitor(s):

Joyce Kix, RN
Lori Miner, RN BSN

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:	35
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	35
TOTAL census of Assisted Living Program	35

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

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant asked a staff member for sexual favors in exchange for money.

- Monitoring Observation: Incident reports dated 4-30-12 documented an event of that evening. Staff #1 had come to pick up her paycheck. She noticed Staff #3 and two other boys in the parking lot in the front of the Program. By the time Staff #1 got to the parking lot, two of the boys were gone and Staff #1 noted the shades on the windows of Tenant #1's apartment were closed, something Staff #1 had never seen since Tenant #1 moved into the Program. Staff #1 went into the Program and asked Staff #2, the Certified Nursing Assistant (CNA) on duty, to check on Tenant #1. Staff #2 went to Tenant #1's apartment, knocked on the door, entered with a key because the door was locked and found Tenant #1 exposed with pants to the knees. Tenant #1 was pointing toward the corner where Staff #3 (a minor) and another boy, a friend of Staff #3, were standing. Staff #2 asked them to leave the apartment. Staff #3 stated "I wanted the notes to stop." The friend stated "He was scared to go alone" so the friend went with Staff #3 to Tenant #1's apartment.

  Tenant #, a 79 year-old, was admitted on 9-21-08 and had diagnoses of: Deaf, Non-speaking, Congenital Talipes Equinovarus (Clubfoot), and Cystotomy to Remove Foreign Objects from Bladder. Tenant #3 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline.

  Staff #3 stated he had been delivering papers to tenants at the Program for four years prior to beginning employment as a dietary aide in March 2009. Staff #1 stated Staff

#3 told her that when Staff #3 was delivering papers Tenant #1 had gotten Staff #3 into the apartment and Tenant #1 acted inappropriately. Staff #1 stated Tenant #1 had lived at the Program for several years and during this time Tenant #1 had shown attention to the boys that have been employed at the Program by trying to talk to them, inviting them to Tenant #1's apartment, and writing notes. Staff #1 stated there had been several dietary aides and CNA staff that Tenant #1 had been attracted to, especially former staff member, Staff #4.

Staff #3 stated he began receiving notes from Tenant #1 but did not tell anyone right away. Staff #3 described the notes as "gross and nasty." Staff #3 went with a parent to discuss the notes with the housing manager, Staff #5, who is no longer employed at the Program. Staff #3 was instructed to report any further notes.

The Nurse reported in August 2011, Staff #1 reported to her Tenant #1 was following Staff #3 and #4 around when they were working and Tenant #1 was writing notes to them. The Nurse reported the information to Staff #5, the housing manager at the time.

Staff #3 reported the notes continued, and Staff #4 also received notes. Staff #3, his parent, and Staff #4 again went to speak to Staff #5, the prior housing manager. Staff #5 told the Nurse she had spoken with Staff #3 and #4 and the family of Tenant #1. In a statement, Staff #5 revealed concerns were brought to her attention by Staff #3, a parent of Staff #3, and Staff #4 regarding inappropriate behavior. Staff #5 revealed she gave them a note to show the tenant, stating "Please return to your apartment, the staff has work to do." Staff #3 confirmed Staff #5 made a note to be handed to Tenant #1, who was deaf and mute, when Tenant #1 was following the boys around. Staff #5 stated Staff #4 had been given a note by a tenant saying "I love you." The tenant would leave money at the supper table and Staff #5 instructed staff to leave the money on the table.

A fax dated 9-9-11 and signed by Staff #5 indicated Tenant #1 had been following an orderly throughout the building. Attempts made to redirect Tenant #1 were unsuccessful. The week prior Tenant #1 had been "hanging around" the kitchen as a male dietary aide was doing dishes. The dietary aide left the kitchen, Tenant #1 followed, unzipped pants, and the dietary aide left the area and reported the incident to the person in charge. The fax dated 9-9-11 and sent to the physician questioned the use of a patch to decrease hormone levels.

Care notes dated 9-9-11 outlined the incident described in the fax. The notes stated a family conference had been held with the family and Tenant #1 on 9-2-11 "regarding these types of behavior." On 9-9-11, a physician ordered a Clonidine patch to be applied weekly. The patch was to be held if the blood pressure was low. The family of Tenant #1 was to apply the patch; the Program was not administering medications to Tenant #1 at the time. The Nurse revealed it was decided to apply a patch "which would decrease Tenant #1's sexual urges."

According to the service documentation record for Tenant #1 and the Nurse, Program staff members were checking Tenant #1's blood pressure prior to the application of the patch by Tenant #1's family. A notation indicated blood pressure checks were discontinued on 12-8-11 because the family was no longer applying the patch.

According to the Physician, a family member reported areas on Tenant #1's back where the patch had been applied had become inflamed. The family reported inappropriate sexual behavior was no longer a concern. According to Staff #6, a scab had developed on Tenant #1's back and Staff #6 thought the patch had not been rotated.

Tenant #1 had a case manager from the local agency on aging. Case Manager #1 stated she met with Tenant #1 in the apartment. Tenant #1 would pull out a medical dictionary, point to the word "penis," and laugh. Case Manager #1 stated Tenant #1 would leave the apartment door unlocked while masturbating. Case Manager #1 transferred care of Tenant #1 to Case Manager #2 in December 2011. Case Manager #2 stated she assumed care of Tenant #1 in January 2012. Case Manager #2 stated she met with Tenant #1 in the library of the Program and had no problems with inappropriate behavior.

Care notes dated 1-4-12 indicated Tenant #1 was taken to the hospital for "throwing up blood." Tenant #1 returned to the Program on 2-23-12 and the Program began administering medications to Tenant #1. The medication orders upon return did not include an order for the Clonidine patch. Staff #1 revealed at that time Tenant #1 started to "hang around" and try to get the attention of male dietary aides. Tenant #1 also had notes in the apartment stating the name of Staff #4 and "I love Staff #4." According to the Nurse, a week prior to the 4-30-12 incident, Staff #6 had reported the signs had Staff #4's name and a note regarding Tenant #1 holding Staff #4 and Staff #4 holding Tenant #1. On 5-8-12, the Part-time Nurse stated she had noticed several more signs in Tenant #1's apartment in the last week with Staff #4's name on them.

After permission was received from Tenant #1, the monitors entered Tenant #1's apartment. There were at least 15 signs in Tenant #1's handwriting with Staff #4's name on them. Staff #7 stated Tenant #1 used to have "just a couple" signs with Staff #4's name.

Staff #3 reported the handwritten notes to him continued, 50 in all. According to Staff #3 on the evening on 4-30-12, while Staff #3 was doing the dishes, Tenant #1 came into the kitchen and proceeded to gesture a masturbating motion with a finishing noise. Tenant #1 put his finger to his mouth which indicated Staff #3 should keep quiet. Staff #3 got Tenant #1 to leave the kitchen. When Staff #3's shift ended, Staff #3 met friends outside the building and stated to the friends "I wish I could get this to stop," but Staff #3 did not want to do it alone. A friend volunteered to accompany Staff #3 to Tenant #1's apartment. Staff #3 indicated the door was unlocked upon entering, and Tenant #1 handed Staff #3 some money and walked near the door. When a knock came at the door, Tenant #1 motioned to Staff #3 and the friend to hide, so they did. Staff #3 and the friend were asked to leave, and Staff #3 estimated the time in the apartment to be two minutes at most. Staff #3 left the building, got to the parking lot, remembered the money, and went back into the Program to return the money to Staff #2. Staff #3 stated there was no touching between Staff #3 and Tenant #1 during this incident

On 4-30-12 Staff #1 had come to pick up her paycheck. She noticed Staff #3 and two other boys in the parking lot in the front of the Program. By the time Staff #1 got to

the parking lot, two of the boys were gone and Staff #1 noted the shades on the windows of Tenant #1's apartment were closed, something Staff #1 had never seen since Tenant #1 moved into the Program. Staff #1 went into the Program and asked Staff #2, the Certified Nursing Assistant (CNA) on duty, to check on Tenant #1. Staff #2 went to Tenant #1's apartment, knocked on the door, entered with a key because the door was locked and found Tenant #1 exposed with pants to the knees. Tenant #1 was pointing toward the corner where Staff #3 and another boy, a friend of Staff #3, were standing. Staff #2 asked them to leave the apartment. Staff #3 stated "I wanted the notes to stop." The friend stated "He was scared to go alone" so the friend went with Staff #3 to Tenant #1's apartment.

The Program suspended Staff #3 until an investigation could be completed. The Sheriff's Department was also notified.

The Tenant Agreement signed by Tenant #1 and Tenant #1's power of attorney on 9-18-09 stated the Program shall have a policy of terminating the agreement, in its discretion, if a tenant is dangerous to self or other tenants or staff, including but not limited to a tenant who despite intervention is sexually or physically aggressive or abusive. The Tenant Agreement also acknowledged Tenant #1 agreed to abide by the general policies in the Tenant Handbook. The Tenant Handbook stated management reserved the right to decide when a tenant was no longer physically or psychosocially able to reside in the assisted living environment.

Tenant #1 was seen unzipping pants and following a dietary aide in September 2011. Staff #3 had spoken with the former housing director, Staff #5 on two occasions. In response the Program tried using notes handed to Tenant #1 to indicate staff members were working without success to stop behaviors. A Clonidine patch was prescribed without success. Staff #3 attempted to intervene on 4-30-12. Tenant #1 was found exposed with pants to the knees with the dietary aide and friend present. Despite intervention, Tenant #1 is sexually aggressive.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: (c) Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1)(c)(1))

B. Evaluation

- Monitoring Observation: Tenant #1 had been prescribed a Clonidine patch in September 2011 to suppress sexual urges. The patch was stopped in December 2011. Tenant #1 was hospitalized in January 2012 and returned to the Program in February. The medication orders at that time did not include a Clonidine patch. Since returning from the hospital Tenant #1 had begun trying to get the attention of male dietary aides, sometimes with graphic notes or gestures, and had been increasing the number of handwritten signs with a former staff member's name. Tenant #1 had demonstrated continued or increased sexual aggression which resulted in Staff #3 entering Tenant #1's apartment in an attempt to get the behavior to stop. Functional, cognitive and health evaluations were not completed following the incident of 4-30-

12 to determine Tenant #1's continued eligibility for the Program and to determine any changes in services needed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plans

- Monitoring Observation: The current service plan was dated 2-23-12 with an addition dated 3-2-12 following a fall. The health history indicated Tenant #1 was deaf and mute. The monitors were advised when going to Tenant #1's apartment to open the door slightly, reach for the light switch, and switch the light off and on before entering the apartment. The service plan did not identify the use of the light switch when entering the apartment. The service plan did not identify how the staff members should respond when finding Tenant #1 masturbating in the apartment. The service plan indicated staff members should report to the nurse if any inappropriate behaviors were observed. The service plan did not identify interventions when staff members were confronted with graphic notes and gestures. The service plan did not identify handing notes to Tenant #1 to indicate staff members were busy as a way to discourage staff members being followed by Tenant #1. The service plan did not meet the needs of Tenant #1 or direct staff with appropriate responses to behaviors.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

D. Nurse Review

- Monitoring Observation: Tenant #1 had been prescribed Clonidine patches in September 2011 to decrease sexual urges following an episode of Tenant #1 unzipping pants after following a dietary aide. The patch was discontinued in December 2011. Tenant #1 was hospitalized in January 2012 and returned to the Program in February 2012. Tenant #1 resumed behaviors of following male dietary aides, giving graphic notes to male staff members, and making sexual gestures. Within the last few weeks Tenant #1 has placed at least 15 signs in the apartment with the name of a former CNA. On 4-30-12 Tenant #1 was found locked in the apartment by Staff #2 who witnessed Tenant #1 exposed with pants to the knees with a dietary aide and friend present. A nurse review was not completed to determine the effectiveness of the Clonidine while the patch was in use, the effect on Tenant #1's behavior once the patch was discontinued, or the further referral or evaluation of Tenant #1 by a physician because of behavior.

- 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: (3) 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))