IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 39746-C
39659-I

July 11, 2012

Megan Adams, Administrator
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

RE: Final Complaint/Incident Investigation Report – Courtyard Estates at Hawthorne Crossing, Bondurant, IA

Dear Ms. Adams:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 5, 2012, 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 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:

Megan Adams, Administrator
Courtyard Estates Assisted Living
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

Complaint/Incident Intake #: 39746-C
39659-I

Date of Complaint/Incident Investigation:

July 5, 2012

Monitor(s):

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	18
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	24

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	34

Program History – The program received regulatory insufficiencies in the areas of: Policy and Procedures, Service Plan, Staffing and Tenant Rights during the July 5, 2012 Recertification on-site.

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

A. Staffing

Complaint/Incident Allegation: The Program reported a staff member pushed a tenant when she felt threatened by a tenant. The tenant was naked at the time, blocked the staff member's exit from the room, and requested sex from the staff member.

- Monitoring Observation: On 6-25-12 the Program reported to the department an incident that occurred on 6-24-12. Staff #1 was in Tenant #1's apartment assisting the tenant with a shower. Tenant #1 was reported to have made sexual remarks. Tenant #1 was standing naked in the bedroom, moving closer to Staff #1 and blocking Staff #1's exit from the room. Tenant #1 stated he/she wanted to have sex. Staff #1, who was frightened, raised her voice and said "let me out." Tenant #1 was reported to have moved closer. Staff #1 pushed Tenant #1 out of the way. Tenant #1 fell against the bed and slid to the floor. Staff #1 made sure Tenant #1 was in a secure position, and ran out of the apartment. Staff #1 went to the kitchen and notified the kitchen workers of the event. According to Staff #2, the cook, Staff #1 came running down the hallway, shaking and crying, and stated that Tenant #1 had shut the door and grabbed Staff #1 and told her to take her clothes off. Staff #1 reported to Staff #2 that Tenant #1 was on the floor because Staff #1 pushed her arms out and thought Tenant #1 was on the floor. Staff #2 contacted the universal worker assigned to the dementia unit, Staff #3. Staff #3 stated Tenant #1 was on the floor. Abrasions were noted on Tenant #1's "bottom," not open and not bleeding. Tenant

#1 asked Staff #3 if she was married, and also stated "she pushed me." Staff #3 completed Tenant #1's shower without incident. Staff #1 reported the incident to the Administrator and completed an incident report. Staff #1 was suspended pending the outcome of the investigation. The Nurse reported this was the first time any incident of inappropriate sexual behavior had been reported to her. There have been no reports since. As of the date of the monitoring visit, Staff #1 was still suspended. The Program conducted an investigation including interviews with staff members and other tenants. Staff #4 indicated to the Program Tenant #1 had winked at her and she felt uneasy, but was able to remove herself from the situation. Tenants living near Tenant #1 reported no inappropriate behavior. The Program interviewed Tenant #1 who indicated statements made to Staff #1 were misunderstood. Tenant #1's family reported to the Program that Tenant #1 had a previous instance of a similar inappropriate conversation while being treated for a hip fracture "years ago" and was related to a urinary infection and medications.

Staff interviews were conducted. Staff #2, #3, #6, and #7 reported no knowledge of any tenant being sexually inappropriate. Staff #4 reported Tenant #1 winked at her, but knew of no other instances between any tenants and/or staff of sexually inappropriate behavior or language. Staff #5 stated Tenant #1 winked at her but she did not believe it was a sexual gesture. Staff #5 knew of no instances between any tenants and/or staff of sexually inappropriate behavior. The Activity Director reported Tenant #1 winked at her but she did not believe it was a sexual gesture. The Activity Director knew of no instances between any tenants and/or staff of sexually inappropriate behavior.

Tenant #1, a 92 year-old, was admitted on 9-6-11 and had diagnoses of: Benign Prostatic Hypertrophy, Osteoarthritis, Hypothyroidism and Prostate Cancer. The Program completed functional, cognitive, and health evaluations on 6-24-12. Tenant #1 had two errors on the Short Portable Mental Status Questionnaire which indicated normal mental functioning. Tenant #1 resided in the assisted living portion of the building which was dementia-specific by definition. The service plan was updated and indicated male staff members were to assist Tenant #1 with showers. The service plan was also updated to direct staff response in the event Tenant #1 is inappropriate. Tenant #1 was seen by a physician on 6-25-12 for the abrasions sustained in the fall, a complaint of shoulder discomfort related to the fall. A urinalysis, to rule out a urinary tract infection, was negative. Tenant #1 was taken to the emergency room on 6-26-12 following an episode where Tenant #1 became nonverbal and was staring blankly. Tenant #1 returned to the Program the same day. The nurse completed evaluations following the return from the hospital. According to the nurse, there have been no further instances of sexually inappropriate behavior.

The nurse and Administrator were interviewed. A staff meeting was to be conducted on 7-5-12, during the monitoring visit. Training was to be conducted on redirection, intervention and approach in uncomfortable situations, requesting assistance, and reporting behaviors. Staff members were observed attending the meeting. The nurse and the Administrator also stated if Staff #1 was to return to the Program, individual training would be completed.

Six staff training files were reviewed. All files contained current documentation of mandatory dependent adult abuse training and dementia education.

It was reported Tenant #1 was sexually inappropriate with Staff #1. No other episodes of inappropriate behavior by Tenant #1 or any other tenant was identified. Tenant #1 was evaluated by the Nurse and a physician. The service plan was updated to provide staff direction to handle behaviors with Tenant #1. Additional training was provided to staff on uncomfortable situations.

- Regulatory Insufficiency: None noted.

B. Evaluation

Complaint/Incident Allegation: It was alleged a tenant in the dementia unit pushed a staff member against the wall.

- Monitoring Observation: Incident reports for the last three months were provided by the Program. One incident report dated 7-4-12 indicated Staff #8 was pushed into an apartment wall by Tenant #2. Interviews with Staff #3, #4, #6, #8 and the Activity Director indicated knowledge of the incident on 7-4-12 but knew of no other instances where a tenant struck a staff member.

  Tenant #2, a 78 year-old, was admitted on 3-15-12 and had diagnoses of: Hypertension, Coronary Artery Disease, Depression, Benign Prostatic Hypertrophy, Hypothyroidism, and Dementia. Tenant #2 was staged at five on the Global Deterioration Scale which indicated moderately severe cognitive decline. Tenant #2 resided in the locked dementia unit.

  On 7-4-12 at approximately 11:30 a.m., Tenant #2 was escorted, along with other tenants from the dementia unit, to the main dining room in assisted living for lunch. Tenant #2 seemed aggravated and wanted to return to the apartment, so Staff #8 escorted Tenant #2 back to the dementia unit. Tenant #2 hit Staff #8 with a cane. Staff #8 opened the door to Tenant #2's apartment and Tenant #2 pushed Staff #8 into the wall of the apartment. Staff #8 stated she had a muscle contusion as a result of the incident. Staff #3, who primarily worked in the dementia unit, stated this was not usual behavior for Tenant #2.

  The Nurse was contacted who directed staff to send Tenant #2 to the hospital. According to the Activity Director, a family member was contacted and took Tenant #2 to the hospital. The Activity Director stated she stayed in the dementia unit with Staff #8 until Tenant #2 went to the hospital. The discharge instructions from the hospital dated 7-4-12 and timed at 6:49 p.m. indicated Tenant #2 was diagnosed with a urinary tract infection and was placed on antibiotics. Tenant #2 returned to the Program late in the evening. Tenant #2 was also prescribed a medication for agitation, and had a mental health evaluation scheduled for later in the month. The service plan identified redirection strategies. Tenant #2 was observed on two occasions during the onsite visit. Tenant #2 was observed to be interacting appropriately with staff members and was calm.

  Nurse's notes dated 5-27-12 documented an incident where Tenant #2 became agitated and started hitting the window with a cane. Tenant #2 was seen at the

hospital, medications were adjusted, and Tenant #2 returned to the Program. A nurse review was completed. There was no documentation Tenant #2 caused injury to a staff person during this episode. There were no documented episodes of physically aggressive behaviors documented in the nurse's notes prior to the incident of 7-4-12. A pattern of physical aggression was not established.

In an interview with the nurse, she stated if a staff member required assistance, another staff person was always available. The entrance form completed by the Program indicated there were always two staff persons in the building. Interviews with Staff #3, #4, and #5 also indicated two staff persons were in the building at all times. Staff members were going through training on 7-5-12. Training was to be conducted on redirection, intervention and approach to uncomfortable situations, requesting assistance, and reporting behaviors.

Tenant #2 became physically aggressive on 7-4-12. Tenant #2 was taken to the hospital, diagnosed with a urinary infection, started on antibiotics, given medication for agitation, and had an appointment with a mental health specialist scheduled later in the month. Staff members were being trained on redirection and interventions. A pattern of aggression was not established. Staff members were available if assistance was required.

- Regulatory Insufficiency: None noted.