IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 44122-I

July 26, 2013

Mr. Clayton Ward, Executive Director
Fountains Assisted Living
3752 Thunder Ridge Road
Bettendorf, IA 52722

RE: Final Complaint/Incident Investigation Report – Fountains Assisted Living, Bettendorf, IA

Dear Mr. Ward:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 16, 2013, 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 515/281-4116 or **James.Berkley@dia.iowa.gov**

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:

Clayton Ward, Executive Director
Fountains Assisted Living
3752 Thunder Ridge Road
Bettendorf, Iowa 52722

Complaint/Incident Intake #:

44122-I

Date of Complaint/Incident Investigation:

July 16, 2013

Monitor(s):

Maribeth Freland RN

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:	37
Number of tenants with cognitive disorder:	15
Total Population of Program at time of on-site	52

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	17
TOTAL census of Assisted Living Program	69

Program History – The program received regulatory insufficiencies in area of Life Safety during this certification period,

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

B. Tenant Rights

Complaint/Incident Allegation: It was reported one tenant was injured during an un-witnessed incident. An outside provider alleged questionable physical abuse by the tenant's spouse, who also resided at the program.

- Monitoring Observation: The program reported Tenant #1 and Tenant #2, a married couple, both resided at the program. Tenant #1 resided in the memory care unit and Tenant #2 resided in the assisted living part of the building. Tenant #2 spent most of his/her time in the memory care unit with his/her spouse and frequently slept in the memory care unit with the spouse at night.

  Tenant #1, a 78 year old, was admitted to the program on 12-28-12 with the diagnoses of: Facial Neuralgia; Migraines; Dementia; Adult Failure to Thrive; Hypertension and a History of Falls. Tenant #1 scored a 6 on the Global Deterioration Scale completed on 6-5-13, indicating severe cognitive decline. Tenant #1 received hospice services from an outside agency and resided in the program's memory care unit.

Tenant #2, a 76 year old, was admitted to the program on 12-28-12 with the diagnosis of Coronary Artery Disease. Tenant #2 answered all but four questions correctly on the Cognitive Ability Assessment completed on 4-15-13, indicating low risk of cognitive impairment. Tenant #2 maintained an apartment in the program's assisted living part of the building but spent the majority of time staying in his/her spouse's apartment in the memory care unit, including sleeping in the apartment with the spouse.

Tenant #1's clinical record indicated Tenant #2 entered the apartment in the memory care unit on 5-30-13 at approximately 10:45 p.m., noting Tenant #1 on the floor beside the bed. Tenant #2 lifted Tenant #1 back onto the bed, noting Tenant #1's left ear was bleeding. Tenant #2 immediately sought staff members to assist Tenant #1. Staff members indicated Tenant #1 had been assisted to bed at approximately 8:30 p.m. that evening and had been checked on approximately every 30 minutes between 8:30 p.m. and 10:15 p.m. with Tenant #1 being observed to be laying under the covers with his/her head at the top of the bed. Tenant #2 was observed by staff members to be in and out of the apartment during this same time. At 10:30 p.m., staff members observed Tenant #2 walk into the memory care apartment. After a few minutes, he/she exited the apartment seeking assistance for Tenant #1. Staff #1 and Staff #2, both direct care workers, responded to assist Tenant #1. Tenant #1 was found to be laying on top of the covers with his/her head facing the foot of the bed. Tenant #1 had two cuts on the left outer upper ear lobe. Compression was applied to the ear to stop the bleeding and the cuts did not require suturing. A small bed side table was located on the left side of the bed at the time of the incident. The program moved the bedside table following the injury, assuming Tenant #1 had rolled out of bed, hitting his/her ear on the table.

On 6-3-13, an on-call hospice nurse who had visited Tenant #1 over the weekend contacted the program administration and reported in her opinion Tenant #2 may have hit Tenant #1 in the ear causing the injury; therefore, the hospice nurse planned to report the incident to the Department of Human Services as potential dependent adult abuse.

On 6-5-13 the program Director of Nursing interviewed Tenant #1 by asking yes and no questions. Tenant #1 indicated he/she was not fearful of Tenant #2. loved Tenant #2 and had never been hit or hurt by Tenant #2.

During interview, Tenant #2 reported he/she had been up walking around the assisted living first floor and the memory care unit. Tenant #2 walked into the memory care apartment he/she shared with Tenant #1, noting Tenant #1 lying on the floor in a hunched over position with head toward the top of the bed. Tenant #2 lifted Tenant #1 back onto the bed at which time Tenant #2 noted Tenant #1's left ear had some blood on it. Tenant #2 left the room and sought staff members who immediately came to the apartment. Tenant #2 reported he/she believed Tenant #1 had injured his/her ear by striking the ear on the bedside table when rolling out of bed. Tenant #2 was very weepy when talking about his/her spouses decline in health status.

During interview, Staff #1, Staff #2, Staff #3 and Staff #4, all direct care workers, reported being familiar with both Tenant #1 and Tenant #2. All four staff members reported Tenant #2 was very affectionate toward his/her spouse, frequently holding hands, placing an arm around the spouse, touching Tenant #1's hand or thigh in a loving manner and sleeping in a cuddling position. All four staff members denied witnessing Tenant #2 acting in a physically aggressive manner toward Tenant #2, any other tenants or any staff members. All four staff members denied witnessing Tenant #1 acting fearful of Tenant #2.

During interview, Staff #5, Assistant Director of Nursing, reported she had never noted Tenant #2 exhibiting physically aggressive behaviors toward Tenant #1, other tenants or staff members. The Assistant Director of Nursing reported she had never noted Tenant #1 to have any unexplained injuries and had never noted Tenant #1 to be fearful of Tenant #2. The Assistant Director of Nurse reported she felt Tenant #2's recounting of the incident which resulted in Tenant #1's left ear injury appeared to be plausible and did not have any concern of physical abuse of Tenant #1.

The program initially separated Tenant #1 and Tenant #2 as much as possible, required Tenant #2 to leave the memory care apartment door open at all times and checked on Tenant #1 every 15 minutes. The program notified Tenant #1 and #2's daughter who was documented as the emergency contact to report the incident following the hospice nurse's allegations. Documentation indicated the daughter did not want her parents separated as Tenant #1 always demonstrated more calmness when Tenant #2 was present rather than absent from Tenant #1's surroundings. The program began allowing Tenant #2 to be back in the memory care apartment on 6-6-13 but continued to request the door remain open at all times and continued the every 15 minute checks through 7-5-13, noting no further concerns with inappropriate behavior.

The monitor reviewed the incident reports from January through July 2013, noting Tenant #1 experienced no other falls or injuries. The monitor noted no suspicious incidents involving any other tenants residing at the program. The program identified no other tenants who exhibited aggressive physical behaviors or inappropriate sexual behaviors.

The incident reports documented one other incident involving Tenants #1 and #2. On 7-11-13, staff members observed Tenant #1 and Tenant #2 engaged in a sexual act. Tenant #2 was cuddling with Tenant #1 and manually stimulating Tenant #1 sexually. Tenant #1 was not exhibiting any symptoms of fear or unwillingness to participate. Tenant #1 was not crying out during the interlude. Tenant #2 was fully clothed during the act. Staff members knocked and entered the room, noting Tenant #1 had been incontinent of urine. Staff members requested Tenant #2 leave the apartment while they cleaned Tenant #1 up. Tenant #1 did not appear to be fearful and neither staff members noted any injury to Tenant #1. The incident was reported to the program's administration immediately and Tenant #1 was assessed by Staff #5, Assistant Director of Nursing. Staff #5 documented finding no negative outcomes or behaviors exhibited by Tenant #1. Staff #5 noted no injury to Tenant #1.

Tenant #1 and #2's service plan, dated 4-15-13, indicated Tenant #1 and Tenant #2 still have sexual intercourse.

During interview, Staff #1 and Staff #2 denied ever witnessing sexual interactions between Tenants #1 and #2. Staff #3 and Staff #4 reported witnessing only the one sexual interaction between Tenants #1 and #2 on 7-11-13.

During interview, Tenant #2 reported he/she had been married for 50 plus years to Tenant #1 and had always shared a loving, sexual relationship. Tenant #2 reported the sexual relationship continued after admission to the program but now had changed to manual stimulation rather than sexual intercourse. Tenant #2 expressed a good understanding of his/her spouse's cognitive decline and the potential need to stop the sexual behavior should Tenant #1 begin to act afraid or unwilling to participate due to the cognitive decline. Tenant #2 denied ever noting Tenant #1 to act afraid or in pain during the sexual interactions.

The monitor visited with Tenant #1. Tenant #1 was able to answer yes and no to questions asked by the monitor. The monitor asked unrelated questions to determine the validity of answers by Tenant #1, finding the answers to be appropriate in context. Tenant #1 denied feeling afraid of Tenant #2, denied being hit or hurt in any other way by Tenant #2, any other tenants or any staff members and denied being hurt sexually by Tenant #2, any other tenants or any staff member. Tenant #1 reported he/she loved Tenant #2 and it was okay for Tenant #2 to kiss him/her and touch his/her private body parts.

During interview, Tenant #1 and #2's daughter reported she had been contacted by the program following the 5-30-13 injury to Tenant #1's ear and the 7-11-13 sexual encounter between Tenant #1 and Tenant #2. The daughter reported there had been no past history of physical or sexual abuse of Tenant #1 by Tenant #2 or vice versa. The daughter reported both tenants would "bat back and forth verbally but nothing physically". The daughter continued to report a wish to have Tenant #1 and Tenant #2 to be allowed to have unrestricted contact as Tenant #1's dementia and anxiety seemed to be much lessened when Tenant #2 was present.

The program followed up appropriately to the un-witnessed injury. The injury could be explained by the circumstances. Tenant #2's report of the incident made sense. Tenant #1 did not exhibit fearfulness of Tenant #2. The sexual interaction appeared to be mutually enjoyed. No injury to Tenant #1 was noted and Tenant #1 indicated an approval to be touched in a sexual manner by Tenant #2.

- Regulatory Insufficiency: None noted.