IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 44897-I

September 13, 2013

Ms. Tiffany Reiter, Director
BeeHive Homes Assisted Living
2116 1st Avenue East
Spencer, IA 51301

RE: Final Complaint/Incident Investigation Report – BeeHive Homes Assisted Living, Spencer, IA

Dear Ms. Reiter:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 3 and 4, 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:

Tiffany Reiter, Director
BeeHive Homes Assisted Living
2116 1st Ave. East
Spencer, Iowa 51301

Complaint/Incident Intake #:

44897-I

Date of Complaint/Incident Investigation:

September 3 and 4, 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.

General Population Program	
Number of tenants without cognitive disorder:	9
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	10

Program History – The program received regulatory insufficiencies in the area of Evaluation of Tenants during this certification period.

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

Program Reporting to the Department

Complaint/Incident Allegation: The program reported a tenant spent one night in a staff member's apartment three weeks after the incident occurred.

- Monitoring Observation: Tenant #1, a 59 year old, was admitted to the program on 9-30-12 with diagnoses of Chronic Obstructive Pulmonary Disease, Depression and History of Alcohol Abuse. Tenant #1 answered all but one question correctly on the program's cognitive assessment indicating no cognitive decline. Tenant #1 was independent with all activities of daily living. Tenant #1 made independent day to day decisions. Tenant #1 did not have an appointed guardian or conservator. Tenant #1 had activated a family member as power of attorney for financial purposes only.

  On 7-12-13, Tenant #1 requested to go home with Staff #1, universal worker, for the night with a plan to return the following morning. During interview, Tenant #1 reported he/she was feeling particularly stressed 7-12-13. Tenant #1 reported he/she enjoyed visiting with Staff #1 and "needed to talk". Tenant #1 reported approaching Staff #1 and requesting to go home with her. Staff #1 agreed to take Tenant #1 home for the evening. Tenant #1 reported they went to the grocery store to up a few items, sat at the dining room table talking and shared a snack while conversing, including one beer. Tenant #1 reported sleeping in a spare room separate from Staff #1. Tenant #1 denied having any intimate contact or intent to the relationship. "I just liked her and enjoyed talking to her." Tenant #1 denied ever asking Staff #1 or any other staff to go home for the evening and had never done this prior to 7-12-13.

During interview, Staff #1 reported she worked the evening shift on 7-12-13. Around supper time, Tenant #1's power of attorney for financial affairs came to visit. After the power of attorney left the program, Tenant #1 told Staff #1 he/she felt stressed about a family member being in the hospital. Staff #1 reported shortly before the end of her shift, Tenant #1 came to her and requested to go home with her for the night. Tenant #1 indicated he/she felt stressed and needed to "get out of here" to de-stress. Staff #1 reported she told Tenant #1 she had a spare room that Tenant #1 could use for one night if needed to de-stress. Staff #1 took Tenant #1 with her when she left work for the night. While gone, they went to the grocery store to pick up a few items, sat at the dining room table allowing Tenant #1 to "vent" until 5:00 a.m., shared a snack and then went to sleep in separate rooms. Staff #1 denied any intimate contact or intimate intent to the relationship. Staff #1 denied ever taking Tenant #1 or any other tenants residing at the program to her home prior to 7-12-13. Staff #1 reported Tenant #1 had never asked to go to her home prior to 7-12-13.

Staff #1 brought Tenant #1 back to the program the following morning unharmed. The Director spoke with Tenant #1 to determine the activities of the evening prior. Tenant #1 reported the activities as stated above. Tenant #1 denied having any intimate contact with Staff #1 prior to or during the night of 7-12-13. Tenant #1 denied having any social or intimate intent to his/her relationship with Staff #1. Tenant #1 denied being harmed in any way while at Staff #1's home.

During interview, the Director reported Tenant #1 returned from the overnight stay at Staff #1's home in a happy mood and denied any intimate relationship with Staff #1. Tenant #1 admitted to drinking one beer while out with Staff #1. The Director reported Tenant #1 did not smell like alcohol and did not appear intoxicated upon return to the program. The Director reported she did not report the incident to the Department of Inspections and Appeals immediately as she felt there was nothing to report after determining Tenant #1 denied any intimate contact had occurred. Approximately three weeks later, the Director was told by the local tenant advocate that she should have reported the incident so the Director reported it on 8-8-13.

The monitor interviewed Staff #2, #3 and #4, all universal workers employed at the program. All three staff members reported seeing no signs of inappropriate contact between Tenant #1 and Staff #1. All three staff members denied ever seeing Staff #1 paying special attention to Tenant #1 or being at the building at any time other than when Staff #1 was working.

Tenant #1 was independent with all activities of daily living, was not cognitively impaired, made his/her own day to day decisions and denied having an intimate relationship with Staff #1. Tenant #1 reported he/she asked to go to Staff #1's home for the evening and returned to the program unharmed. As there was no allegation of sexual misconduct and Tenant #1 was able to make his/her own decisions, the program was not required to report the incident to the Department of Inspections and Appeals.

- Regulatory Insufficiency: None noted.