IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 47079-C
47095-C

April 24, 2014

Ms. Tiffany Reiter, Director
Cobble Creek AL
2116 1st Avenue East
Spencer, IA 51301

RE: Final Complaint/Incident Investigation Report – Cobble Creek AL, Spencer, IA

Dear Ms. Reiter:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of April 8 & 9, 2014, 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: **Complaint/Incident Intake #:** 47079-C & 47095-C

Tiffany Reiter, Director
Cobble Creek AL
2116 1st Avenue East
Spencer, IA 51301

Date of Complaint/Incident Investigation:

April 8 & 9, 2014

Monitor(s):

Margaret Kaltefleiter RN MS
Wendy Kushe RN BS

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:	2
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	11

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:

A. Other

Complaint/Incident Allegation #47079 & #47095: It was alleged the Director came to work after drinking heavily and administered medications.

Monitoring Observation: A community meeting was held with nine tenants. They stated they loved living there, received good care and the food was delicious. Housekeeping services were completed to their satisfaction and the buildings and grounds were safe, clean and sanitary. They used pendants to call for assistance and staff responded within a couple seconds and was very fast. Nursing services were available when needed. They described the care received as excellent, stated staff was nice and treated them well. They responded "yes" when asked if they were treated with respect. One tenant said there was one time when a staff member was found asleep on the job but that staff no longer worked at the Program. The tenants stated they were not aware of staff working under the influence of alcohol. One tenant reported the Director was falsely accused of drinking but she was not drunk and did not sleep on the job. The tenants felt safe, made their own decisions, were generally satisfied with the Program and had recommended it to their friends.

Staff #1 was interviewed and stated she worked from 3:00 p.m. to 11:00 p.m. on Super Bowl Sunday. She called the Director at 11:10 p.m. to inform her no one showed up to work the next shift. She stated the Director sounded tired; she called back 20 minutes later and stated she would work the shift, arriving about 40 minutes later. She said the Director's eyes looked bloodshot and the Director said her husband was concerned about her being able to drive. The Director was very talkative and Staff #1 asked if she was going to be okay.

She told the Director she had some jobs that needed to be done and the Director said "No way," she was going to hit the couch and sleep.

Tenant #1, an 83 year old, was admitted on 8-2-12 and diagnoses include: Diabetes, Asthma, Depression and Pneumonia. Tenant #1 stated on Super Bowl Sunday night the Director was not asleep. Tenant #1 waited until about 4:20 a.m. for an as needed pain medication, started to walk out into the living room and the Director was sitting on the couch and waved at Tenant #1. Tenant #1 asked for the pain medication and the Director got it. The Director did not act drunk, looked tired but she didn't normally work the night shift. Later the nurse asked Tenant #1 if the Director was drunk and Tenant #1 replied "Maybe" but wished he/she hadn't said that since Tenant #1 didn't really know. Tenant #1 loved it there and had no complaints, received good care and was treated with respect. Tenant #1 stated the Director was wonderful.

The Director was interviewed and stated on Super Bowl Sunday she had been at the Program at 9:00 a.m. getting ready for the open house and got home around 2:00 p.m. She drank a beer at that time along with a shot of alcohol and an energy drink. She went to a party but packed a cooler of water as she was the designated driver. Around 3:30 p.m. she had another shot and drank water afterwards, arriving at home during half time. She stated she had no other drinks the rest of that day. She made wings and nachos to eat and went to bed. Around 11:10 p.m. she received a call from staff stating the next shift person had not shown up. She called three staff but no one answered so she came in to work. She stated it took about 30 minutes to drive to the Program. During the shift she prepped food for the next day and did some office work. Tenant #1 was to get a pain medication at 4:00 a.m. or 4:30 a.m. She was sitting on the couch watching television when Tenant #1 came out. She asked Tenant #1 if Tenant #1 needed medication and Tenant #1 replied yes. The Director got the key to open the medication box in Tenant #1's room. She told Tenant #1 she had gone to some Super Bowl parties, Tenant #1 told her she looked tired and the Director replied that she was. The Director left work around 8:00 a.m.

Staff #2 and #3 stated they were not aware of anyone drinking and then coming to work under the influence of alcohol. They stated they were not aware of anyone who had been found sleeping on the job.

Staff #1, #2, #3 and the Director stated there was enough staff to meet the needs of the tenants.

According to a Staffing policy, sufficient trained staff will be available at all times to fully meet tenants' identified needs. The Program will have one or more staff persons awake and on duty 24 hours a day.

Review of a Staffing policy, a Community Meeting, interviews with Tenant #1, Staffs #1, #2, #3 and the Director did not reveal any concerns with the Director reporting to work after drinking heavily and administering medications.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47079 & #47095: It was alleged tenants asked the Director to turn up the heat, she did not because she was hot and the Director told one tenant to just put on another blanket.

Monitoring Observation: A community meeting was held with nine tenants. The tenants said sometimes the building was too cold in the winter but most of the time staff adjusted the temperature when requested. Tenant #1 was interviewed and stated the Director had never told Tenant #1 to put on more blankets.

Staff #1 stated the Program controlled the thermostat and the temperature was adjusted to whatever the Director wanted it to be in her office. She stated staff adjusted the temperature when requested by the tenants. Staff #2 stated tenant requests was honored regarding heating and cooling. Staff #3 stated tenant requests was honored; she also provided extra blankets and would ask other tenants if they were cool and if so, she would turn up the heat. The Director stated tenant requests were honored regarding the temperature. She stated she had never told anyone to put on more blankets and had never adjusted the temperature for what suited her as it was the tenants' home.

Per a Community Meeting and interviews with Tenant #1, Staffs #1, #2, #3 and the Director did not reveal any concerns with the Director not honoring tenants' requests to turn up the heat or directing tenants to use more blankets.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #47095: It was alleged tenants were upset with the way the Director treated them.

Monitoring Observation: A community meeting was held with nine tenants. They responded "yes" when asked if they were treated with respect. They stated they would like to see more of the Director. Tenant #1 was interviewed and had no complaints, received good care and was treated with respect. Tenant #1 stated the Director was wonderful.

Staffs #2, #3 and the Director stated tenants were treated with respect.

According to a Tenant Rights policy, tenants have the right to be treated with consideration, respect and due recognition of personal dignity, autonomy, individuality and the need for privacy.

Review of the Tenant Rights policy, a Community Meeting, interviews with Tenant #1, Staffs #2, #3 and the Director did not reveal tenant dissatisfaction with how the Director treated the tenants.

- Regulatory Insufficiency: None noted.