IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 46643-C
46661-I
46714-I

May 21, 2014

Ms. Roberta Johnston, RN Director
Prairie Hills at Independence
505 Enterprise Drive SW
Independence, IA 50644

RE: Final Complaint/Incident Investigation Report – Prairie Hills at Independence, Independence, IA

Dear Ms. Johnston:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 7, 8, 9 and May 19, 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 515/281-7039 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 #:** 46643-C, 46661-I, 46714-I

Roberta Johnston, RN Director
Prairie Hills at Independence
505 Enterprise Drive SW
Independence, IA 50644

Date of Complaint/Incident Investigation:

January 7, 8, 9 and May 19, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	44
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	45

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	56

Program History – During a complaint investigation on 7-31-12, the program received a regulatory insufficiency in the area of Life Safety.

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

A. Tenant Rights

Complaint/Incident Allegation #46643-C, 46661-I: It was alleged a tenant could potentially have been sexually assaulted. The Program reported a tenant suffered from hallucinations, was transferred to an Emergency Room (ER) and a physical exam revealed perineal bruising.

- Monitoring Observation: Tenant #1, a 90 year old, was admitted on 10-14-13 and diagnoses included: Anemia, Chronic Kidney Disease (Stage 2-3), Anxiety Disorder, Hyperlipidemia, Hypertension (HTN), Osteoporosis, Hypothyroidism, Transient Ischemic Attack and a Lung Nodule. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit.

  According to the Nurse's Notes dated 12-29-13 at 3:00 p.m., the Director was called to the dementia unit due to Tenant #1 holding the door to the outside open, refusing to come in. Multiple attempts at redirection failed, such as, food, drink, offers of calling a family member, offer to get coat and other suggestions. Planned ignoring also failed. Tenant #1 verbally responded to internal stimuli, talked to a puppy outside (that was not there) and made other hallucinatory comments. Much one on one reassurance was attempted by multiple staff. Earlier Tenant #1 had picked up an artificial candle and hit a staff member with it, no injuries. Tenant #1 verbally rambled in English and Spanish with no identifiable physical complaints. Staff

instructed to conduct frequent visual checks as Tenant #1 did go to apartment after approximately 20 minutes of holding outside door open. On 12-30-13, Tenant #1's family took Tenant #1 to the lab for blood tests and delivered urine previously obtained. On 12-31-13 at 7:00 a.m., report from night shift included information that Tenant #1 continued to hallucinate "seeing people in Tenant #1's room." Tenant #1 paced hallways, moved trash can to middle of hallway and cried in the morning. On 12-31-13 at 10:00 a.m. the Director was called to the dementia unit. Tenant #1 was completely delusional, angry, agitated and unable to put any coherent thought/verbalizations together. Offers of diversion activities: food, drink, toileting were all refused. Tenant #1 attempted to get outdoors to the outside and kicked and hit staff with a closed fist when breakfast was offered. Messages were left for family. Tenant #1's physician was contacted and return call received to transport Tenant #1 to the ER for evaluation and treatment. On 12-31-13 at 11:30 a.m. the ambulance arrived to transport. Tenant #1 attempted to strike out at ambulance staff.

According to a service plan dated 12-30-13, Tenant #1 was independent in dining, mobility, hygiene, transfers and toileting. Tenant #1 required assistance with buttons, snaps and zippers due to poor fine motor control; monitored appearance for appropriate clothing choices and assisted to choose something else if necessary, assisted to locate clothing in room if Tenant #1 could not find it. Staff would assist in and out of shower/whirlpool and stand by for safety while Tenant #1 bathed. Staff administered medications. Tenant #1 was oriented to name, but not place or time. Tenant #1 was delusional with hallucinations at times.

According to an Accident and Incident Report dated 12-31-13 at 10:50 a.m., Tenant #1 was delusional, assaultive, attempted to go out the door and hallucinating. All attempts at redirection and interventions failed. Family was notified and Tenant #1 was transported to the hospital.

Staff #1 stated when Tenant #1 first arrived there were no hallucinations but they started a couple weeks later and the longer the time, the worse the hallucinations got. Tenant #1 would see people outside the window. On 12-25-13, Tenant #1 stated seeing grandson outside the window. One morning Tenant #1 was crying, stated a friend fell through the ice. Tenant #1 interacted well with others at meals and had conversations with tablemates and staff.

Staff #2 stated she knew Tenant #1 saw kids playing outside the window and talked about rats. On 12-31-13 she asked Tenant #1 to get dressed. Tenant #1 was wearing a long robe. Tenant #1 got dressed and came out, walked past Staff #2 and tried to walk outside, was hitting and kicking. The Director and Nurse came to the unit and an ambulance was called. Most of the time, Tenant #1 was nice and talkative at meals. Tenant #1 secluded self in the apartment at times.

Staff #3 stated Tenant #1 was easy to get along with when Tenant #1 first arrived. In the last month behaviors increased. If Tenant #1 didn't want to do something, Tenant #1 wouldn't do it. Hallucinations started the previous month, seeing worms on the floor and people here and then gone. Tenant #1 talked about a friend a lot and complained staff was not taking care of the friend. Tenant #1 stated there were rats and heard noises all the time. Tenant #1's shower day was on 12-31-13. Tenant #1 began the day upset and irate, refused a shower. The Director called and said an

ambulance was coming. Staff #3 asked Tenant #1 to get dressed and Tenant #1 stated he/she could not find clothes. Tenant #1's family called on the phone and talked with Tenant #1, who got more upset the longer the call lasted. Tenant #1 was sitting on the bed and went limp, leaned over with no response. The ambulance arrived and when the medics picked up Tenant #1, Tenant #1 started kicking and arms were swinging. A written statement from Staff #3 indicated she provided weekly manicures to Tenant #1. Tenant #1's nails would get rough and uneven and sometimes extended one half inch from the tip of the finger.

Staff #1, #2 and #3 stated none of the other tenants showed any interest in Tenant #1, no male tenants entered Tenant #1's room, they were not aware of anyone physically attacking Tenant #1 and had not witnessed Tenant #1 demonstrating any self-inflicted behaviors.

The Nurse stated no staff had reported any male interactions with Tenant #1 and she had not witnessed any exchanges between other male tenants and Tenant #1. Tenant #1 started having hallucinations shortly after admission that escalated to a point where Tenant #1 saw children outside the window and made other hallucinatory statements.

The Director stated she had been called to the dementia unit on 12-31-13 because Tenant #1 verbalized unreal, delusional and hallucinatory situations over the prior week or so. Staff called later that night and said police were at the Program regarding a possible sexual assault involving Tenant #1. The police officer was provided with copies of Tenant #1's file and allowed to examine Tenant #1's apartment. No items were removed from the apartment at that time. The officer took several pictures of the apartment.

According to the Program's investigation notes, on 1-1-14 the hospital reported Tenant #1 had been cooperative but had not yet been seen by psychiatry. On 1-2-14 the Program bagged up sheets, towels, underwear and sharp objects, including an old sheathed knife from on top of a china cabinet. The police officer picked up the bagged items on 1-4-13. According to the Program's investigation notes, Tenant #1 was started on Zyprexa on 1-5-14.

On 1-7-14, the Program provided staff education regarding Behaviors, Communication and Activities for those with dementia. The Program videotaped the educational presentation to be used as part of new employee orientation.

A community meeting was held with nine tenants. The tenants stated it was a wonderful place to live; staff treated them with respect, knew what services to provide and provided good care. The tenants stated they had no concerns with other tenants entering their apartments uninvited and had not been mistreated by staff or other tenants.

The Program completed an incident report and notified the Department.

Review of Tenant #1's file, staff interviews, Nurse and Director interviews and a community meeting did not identify any issues regarding tenant rights.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #46714-I: The Program reported Tenant #2 found a housekeeper sitting on Tenant #2's bed and shortly thereafter Tenant #2 had money missing.

- Monitoring Observation: Tenant #2, an 84 year old, was admitted on 7-20-12 and diagnoses included: Coronary Artery Disease, History of Carotid Endartectomy Bilateral, HTN, Gastric Esophageal Reflux Disease, History of Gastro Intestinal Bleed and Gout. Tenant #2 was staged at a three on the GDS, which indicated mild cognitive decline. According to a service plan dated 3-21-13, Tenant #2 was independent in all activities of daily living, mobility and transfers and was able to take medications independently from a medication box.

  According to an Accident and Incident Report dated 12-12-13, Tenant #2 reported a potential theft of money on an unknown date, probably sometime during the first week of December.

  According to the Nurse's Notes dated 12-10-13 at 4:00 p.m., the Nurse received a phone call from Tenant #2's family who had visited Tenant #2 and was told when Tenant #2 returned to the apartment, the housekeeping cart blocked the door. Tenant #2 squeezed by and went into the apartment. Tenant #2 found the housekeeper sitting on the bed. The housekeeper jumped, was startled, got up and left. After the housekeeper left, Tenant #2 went into a dresser drawer where money was kept and some of it was missing. Tenant #2 would go to the bank and kept cash in a bank envelope in the drawer. Tenant #2 was not sure how much money was missing. The family relayed the description of the housekeeper as described by Tenant #2.

  According to the Nurse's Notes dated 12-11-13 at 9:00 a.m., the Director interviewed Tenant #2 in Tenant #2's apartment regarding the report of missing money. Tenant #2 stated he/she did not know exactly when this had happened, thought maybe it was around December 3rd, 4th or 5th. Tenant #2 entered the apartment and the housekeeper was sitting on the bed. The cart was blocking the doorway. Tenant #2 stated the missing money wasn't more than $100.00. Tenant #2 showed the Director the top drawer of the dresser where the money was kept. Tenant #2 described the housekeeper.

  According to a Program document, 17 staff was interviewed as part of the Program's investigation. When asked if staff had seen money lying around in Tenant #2's apartment, 15 stated no and 2 reported loose change on the dresser. All 17 responded no when asked if Tenant #2 had stated there was money in the apartment and responded no when asked if they had witnessed or heard anyone discuss taking items from Tenant #2's apartment. Tenant #2 typically kept the apartment locked when gone. The police department was notified of the potential theft and interviewed Tenant #2 on 12-12-13.

  The housekeeper described by Tenant #2 was terminated on 12-9-13 for performance issues prior to the report of the missing money.

Staff #2 stated she had heard from other staff that Tenant #2 had missing money but she had no idea how much. She stated she didn't suspect any coworkers of stealing.

Staff #3 stated she had heard of coworkers missing money but no mention of any tenants having missing money.

The Nurse stated on 12-10-13, Tenant #2's family called and said Tenant #2 told the family member Tenant #2 had money missing. Tenant #2 was out of the room and when Tenant #2 returned, the housekeeping cart was in the main hall but Tenant #2 had to squeeze by it to get into the room. Tenant #2 startled the housekeeper when Tenant #2 went in. The housekeeper was sitting on the bed and hurried up and left the apartment. Afterwards Tenant #2 went into the drawer and thought there was money missing. Tenant #2 described the housekeeper. The Nurse told the Director about this after she received the phone call and the Director talked to Tenant #2.

The Director stated on 12-10-13 the Nurse received a phone call from Tenant #2's family. The next day the Director talked to Tenant #2. The housekeeper didn't fulfill job duties and was terminated prior to the Program's knowledge of the theft. The Director stated there were no other thefts to her knowledge.

The Office Manager stated she oversaw housekeeping and maintenance. She said the housekeeper was terminated the day before the Nurse received a phone call from Tenant #2's family regarding missing money.

Tenant #2 was interviewed and stated the lady who cleaned Tenant #2's apartment was sitting on the bed and was startled by Tenant #2 when Tenant #2 came into the apartment. Later Tenant #2 went to get some money and it was gone. Stated it was "no more than $100.00." Tenant #2 voiced no concerns with any other staff. Tenant #2 stated this happened about a month ago and said nobody ever came in and sat on the bed. Tenant #2 kept money in the top drawer of the dresser, next to the bed. Tenant #2 didn't check money every day, but did check every few days. Tenant #2 showed the monitor the bedroom and opened the dresser drawer. Inside the drawer was a money envelope from a bank, one stack of papers and underwear.

The Program provided a layout of the building and a floor plan of Tenant #2's apartment.

A community meeting with nine tenants was held. They stated they did not have any concerns regarding missing or lost items.

An incident report was completed and the Department was notified.

Review of Tenant #2's file, Tenant #2's interview, staff interviews, Nurse, Director and Office Manager interviews and a community meeting did not identify any issues regarding tenant rights.

- Regulatory Insufficiency: None noted.