IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 48007-C

June 9, 2014

Mr. Rollie Peterson, Vice President
River Ridge and Gardens at Friendship Haven
420 South Kenyon Road
Fort Dodge, IA 50501

RE: Final Complaint/Incident Investigation Report – River Ridge and Gardens at Friendship Haven, Fort Dodge, IA

Dear Mr. Peterson:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of June 3, 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 #: 48007-C**

Rollie Peterson, Vice President
River Ridge and Gardens at Friendship Haven
420 South Kenyon Road
Fort Dodge, IA 50501

Date of Complaint/Incident Investigation:

June 3, 2014

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.

General Population Program/Gardens 300	
Number of tenants without cognitive disorder:	14
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	15
Dementia-Specific Program by Dedication/ Gardens 100/200	
Number of tenants without cognitive disorder:	22
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	30
TOTAL census of Assisted Living Program	45

Program History –The program received regulatory insufficiencies in the areas of Medications and Life Safety during this certification period.

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

A. Staffing

Complaint/Incident Allegation: It was alleged a staff member was sleeping on the job on the night shift in the dementia unit, The Gardens.

- Monitoring Observation: The surveyor arrived onsite just before 5:30 a.m. The entrance door was locked and a phone call was made to the switchboard using the phone in the entryway. The switchboard operator indicated she would contact the staff member from the Gardens 300 area to let the surveyor in. The Gardens 300 is a general population area, and is not a secured dementia unit. Upon entrance to the building the surveyor went into Gardens areas 100 and 200, both locked dementia units. Staff #1 was in the Gardens 200 and Staff #2 was in the Gardens 100. Both were awake upon the surveyor's entrance. Both denied having difficulties staying awake on the night shift.

  Staff #1 stated about a year ago someone had been caught sleeping on the job and no longer was employed at the program. Staff #1 was not aware of any recent incidents.

  Staff #2 stated she had heard a staff member, Staff #3, was found by a security guard sleeping. Staff #2 thought the incident had occurred two to three months ago. Staff

#2 identified the usual security guard as Guard #1. The surveyor went to the switchboard and asked the operator to contact Guard #1. In a phone interview, Guard #1 stated he had not found staff members sleeping in the Gardens locked dementia units. Guard #1 stated he did find a laundry person sleeping in a lounge by the fireside. Guard #1 did not recall a date when the incident occurred, and did not identify the staff member by name.

Staff #4, assigned to Gardens 300 and person that opened the door for the surveyor was interviewed during the onsite investigation. Staff #4 stated the Gardens 300 was not a locked unit. Staff #4 reported having no difficulty staying awake at night. Staff #4 stated she had only heard vague rumors about someone sleeping at night.

Staff #1, #2, and #4 all worked the night shift. They were followed by day shift personnel, Staff #5, #6, and #7. The three day shift personnel were interviewed and stated they had never come to work to find the night shift staff person sleeping. There were never situations where they came to work to find night shift duties not completed unless there was a reason such as an emergency with a tenant.

Incident reports were reviewed for the past three months, March 2014 to current. There were no documented injuries to suspect a tenant had been left unattended.

An informal meeting was held with six tenants in the Gardens 300, the general population unit. The tenants reported call lights were answered in less than five minutes and there were no delays in getting assistance at night. Staff members were reported to treat the tenants well.

An interview was conducted with the Registered Nurse (RN). The RN reported that a staff member had reported hearing from another staff member that a security guard had reported seeing a staff member sleeping at night. In its investigation, the program was unable to determine a date or time the incident was alleged to have occurred. The RN was not notified by the security guard at the time of the incident. Staff #3 had been identified as the person sleeping. At the time the program was notified, Staff #3 had been working in the general population unit according to the RN. The RN stated she conducted an interview with Staff #3 who neither confirmed nor denied sleeping on the job.

When the issue of staff sleeping was brought to the attention of the program, the program contacted the security company. An email dated 3-27-14 documented a meeting to discuss protocol related to security guards observing staff members sleeping. The security guard was to notify the RN immediately of any staff member found sleeping. The program also conducted in-service training with staff members on 4-15-14 in regards to employment expectations. The RN reported an email was sent to all staff members which indicated sleeping on the job was grounds for termination. The RN stated she has also come to work early to make spot checks on the night shift.

The program was not notified of an allegation of a staff member sleeping on the job until after the fact. The program was unable to determine a date or time of the alleged

incident. Upon learning of the allegation, the program took steps to improve notification of events in the future, and conducted a staff in-service as to expectations.

The surveyor did not observe staff members sleeping. No injury or outcome to tenants related to an allegation of staff sleeping was found.

- Regulatory Insufficiency: None noted.