IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

August 6, 2014

Complaint/Incident Intake #: 48878-I

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

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

Dear Mr. Ward:

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report** 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 found during this evaluation.**

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0236** with effective dates of **June 8, 2014** through **June 7, 2016**.

If you have any questions in regard to this certification, 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 Recertification and Complaint/Incident Investigation Report

Assisted Living Program:

Complaint/Incident Intake #: 48878-I

Clayton Ward, Community Director
Fountains Assisted Living
3752 Thunder Ridge Road
Bettendorf, IA 52722

Date of Complaint/Incident Investigation:

July 21 & 22, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS
Michael Rohner, OTR-L

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:	46
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	57

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	16
TOTAL census of Assisted Living Program	73

Tenant/Family Satisfaction Results – A community meeting with 21 tenants was held. They stated they liked living at the Program because of all the nice people, the services received and the staff. Housekeeping services were described as very good and laundry services were exceptional. Buildings and grounds were safe, clean and sanitary. One tenant suggested housekeeping staff should be allowed more time to clean. Nursing services were available when needed and staff responded "pretty fast" within one to three minutes when called for assistance. One tenant stated he/she waited five minutes one time. The tenants received the services expected when they signed the occupancy agreement. A suggestion was made to include the assigned laundry day in the occupancy agreement. The care received was described as very good; staff treated the tenants with respect; knew what services to provide and were trained appropriately. One tenant suggested staff needed to be taught how to make a bed instead of just pulling up the sheet. The tenants said they loved breakfast but did not enjoy supper when sandwiches and chips were served. A variety of meats, vegetables and desserts were offered and the food was served at the appropriate temperature. A request for dark greens was made instead of iceberg lettuce, more variety in sugar free desserts, and more fresh vegetables. Some tenants wanted the vegetables cooked more and others wanted the vegetables cooked less. Tenants liked having an alternative offered at the meals but said sometimes they did not know what the food item was based on the name of the dish. Plenty of activities were offered, sometimes too many. They enjoyed ice cream socials, playing Bingo, dancing and having the art gallery provide presentations. They said the activity director was fantastic and responsive to requests. The tenants felt safe, made their own decisions, were generally satisfied with the Program and had recommended it to others. Suggestions were made to offer free rides to all doctor visits instead of a limit of two per month, to add hand rails to the center aisle hallway on the first and second floors, to add hand rails on the inside of the elevator and to place a yield sign in the driveway at the entrance to the Program.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

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

A. Other

Complaint/Incident Allegation: The Program reported Tenant #1 paged staff and reported taking too many medications.

- Monitoring Observation: Tenant #1, a 68 year old was admitted on 6-18-13 and diagnoses included: Depression and Neuropathy. A service plan dated 5-30-14 indicated Tenant #1 was independent in all Activities of Daily Living and self-administered medications. The service plan indicated Tenant #1 had a history of depression and anxiety. Staff was to notify the RN if Tenant #1 did not get out of bed, come down for meals or appeared sad and had a flat affect. Staff was to notify the RN if Tenant #1 had increased anxiety that was uncontrolled.

  According to an Incident Report dated 6-21-14 at 10:00 a.m., Staff #1 answered a page from Tenant #1 who told her Tenant #1 had taken too many medications. Staff #1 asked if it was an accident and Tenant #1 responded "No" and wanted to go to the emergency room. Staff #1 asked Staff #2 to call 911 and Staff #1 called Tenant #1's family and the on call nurse.

  According to Clinical Notes dated 6-25-14 (late entry), the DON was notified on 6-21-14 that Tenant #1 had paged staff and informed them of taking medications. Per staff, Tenant #1 was alert and oriented and wanted to go to the hospital. A call was made to 911 and Tenant #1 was transported and Tenant #1's family was notified. Prior to the incident, Tenant #1 had not shown visible signs of being upset or anxious, had conversed in the hallway with the Director of Nursing (DON), smiling and waving the afternoon prior. Tenant #1 was admitted to the hospital for at least 72 hours. The hospital contacted the DON to inform her that Tenant #1 not harm self and plan was for a home health psychiatric nurse to see Tenant #1 and staff to manage medications. Tenant #1 returned to the Program on 6-25-14.

  Staff #1 was interviewed and stated Tenant #1 paged and she went up. Tenant #1 said she should call 911 as Tenant #1 had overdosed on anxiety medications. She asked if this was an accident and Tenant #1 said "No." Staff #2 called 911 while Staff #1 got the paperwork ready and called the DON. Staff #1 went through Tenant #1's garbage to see what was taken and she found three prescription bottles without labels. The labels were folded in a way that they could not be read. She called Tenant #1's family who stated they had received a text message from Tenant #1 so they were not surprised. Tenant #1 was wide awake, ready to go to the hospital and anxious to get there. Staff #1 stated Tenant #1 hardly ever paged for assistance, self-administered own medications and never made any comments about suicide. Staff #1 described Tenant #1 as happy and said Tenant #1's daily routine was to visit Tenant #1's spouse in the memory care unit. Tenant #1 had not had a change in routine.

  Staff #2 stated Staff #1 called her up to Tenant #1's room around 11:00 a.m. Staff #1 said Tenant #1 had taken all of his/her anti-anxiety medications and asked her to call 911. She stayed with Tenant #1 who said he/she had sent a text to his/her family.

Staff #2 asked Tenant #1 why he/she had taken all the medications and Tenant #1 said it was because he/she couldn't sleep. The Paramedics also asked Tenant #1 why he/she took all the medications and Tenant #1 said it was because he/she was having trouble sleeping and just wanted to sleep. Staff #2 stated Tenant #1 did not mention suicide; was alert and awake, eyes appeared glazed and Tenant #1 was moving around. She stated there were no signs prior to the incident. Tenant #1 was always pleasant and quiet, usually skipped breakfast but ate lunch and dinner in the dining room.

The DON said she was the nurse on call on a Saturday morning when Staff #1 called and said Tenant #1 had paged and said he/she had taken all his/her pills and wanted to go to the hospital. Tenant #1 wanted to go to sleep. She said 911 had been called and Staff #1 was getting the paperwork ready. The DON told Staff #1 to call Tenant #1's family. When Tenant #1 returned from the hospital she told staff to do 30 minute checks and instructed them on what to look for in regards to depression and to report verbalization of anything regarding increased anxiety.

The RN Training Specialist stated she reported to the Program on Monday and was told Tenant #1 was in the hospital for an overdose of medication. She talked to Tenant #1's family who said they received a text from Tenant #1 that indicated he/she had taken too many pills. Tenant #1 had a history of depression. The family member said Tenant #1 came to a graduation party and described Tenant #1 as "zonked." Tenant #1's doctor was called to straighten out Tenant #1's medication. The family member said he/she didn't think Tenant #1 was trying to kill himself/herself, just wanted to be "zonked" out from the world.

The Community Director was interviewed and stated he received an email regarding the incident with Tenant #1. He asked staff if anything unusual happened in the last few days and he was told no. Once Tenant #1 returned from the hospital he asked how Tenant #1 was doing, wanted to check his/her mood and make sure Tenant #1 was alright. Tenant #1 told the Community Director that the incident was not intentional.

Tenant #1 was interviewed and stated he/she had suffered from clinical depression and major anxiety since 1999 and was hospitalized in 1999 and 2002. Depression reappeared in 2012 and was the reason Tenant #1 moved to the Program. Tenant #1 managed his/her own medications and thought if one pill was good maybe two would help even more. Tenant #1 had a bad day and bad night, woke up and thought he/she needed more to get through the day. Once he/she knew he/she was in trouble and needed help a call for assistance was made. Tenant #1 was admitted to the hospital for five days, was taken off all medications and now was just on one medication. Tenant #1 said he/she was doing extremely well now. Tenant #1 said it was not his/her intention to hurt or harm himself/herself. When asked if taking the medication was a suicide attempt, Tenant #1 responded "Absolutely not." Tenant #1 said he/she only took a few extra pills.

The Program completed an Incident Report and notified the Department.

Review of Tenant #1's file, the Incident Report, interviews with Staffs #1, #2, DON, RN Training Specialist, Community Director and Tenant #1 indicated Tenant #1 did not intentionally attempt to harm oneself.

- Regulatory Insufficiency: None noted.