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**Complaint/Incident Intake #:**
**48771-A**
**48852-I**
**48876-C**

August 18, 2014

Derrick Johnson, Manager
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

**RE: Final Complaint/Incident Investigation Report, Courtyard Estates at Hawthorne Crossing, Bondurant, Iowa**

Dear Mr. Johnson:

Enclosed is the **Final 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, following an investigation by DIA on **July 23, 24, 28 & August 12 & 13, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

**The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter.** It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to 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:**

Derrick Johnson, Manager
Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, IA 50035

**Complaint/Incident Intake #:** 48771-A
48852-I
48876-C

**Date of Complaint/Incident Investigation:**

July 23, 24, 28, and August 12 and 13, 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 | |
|---|---|
| Number of tenants without cognitive disorder: | 12 |
| Number of tenants with cognitive disorder: | 2 |
| Total Population of Program at time of on-site | 14 |

| Dementia-Specific Program by Dedication | |
|---|---|
| Number of tenants without cognitive disorder: | 2 |
| Number of tenants with cognitive disorder: | 19 |
| Total Population of Program at time of on-site | 21 |
| **TOTAL census of Assisted Living Program** | 35 |

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

**A. Tenant Rights**

Complaint/Incident Allegation: The program reported an allegation of dependent adult abuse involving Staff #1 and #2, and Tenant #1 (48852-I). It was alleged staff members were yelling and threatening a tenant, the tenant was pushed into a chair, and the chair was pushed down the hall with staff members laughing at the tenant (48771-A).

- Monitoring Observation: On 6-19-14, the Manager reported to the Department an allegation of dependent adult abuse involving Staff # 1 and #7 and Tenant #1. It was alleged staff members yelled and pushed Tenant #1 into a chair, then pushed the tenant in the chair to the apartment. The program notified the Department that an investigation had been completed and the staff members in the allegation had been separated from Tenant #1.

  Tenant #1, a 90 year-old, was admitted on 2-1-13 and had diagnoses of: Hypertension, History of Falls, Depressive Disorders, Gastroesophageal Reflux Disease, and Dementia. Tenant #1 was staged at five on the Global Deterioration Scale which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

  Nurse's notes dated 5-28-14 documented the staff had reported Tenant #1 was having increased anxiety with agitation. Tenant #1 was "frantically" pacing the hallway looking for a baby. The nurse's notes indicated the physician was contacted to review medications.

The Manager was interviewed and relayed the following information: Tenant #1 was agitated and had been taken to the apartment in a chair. The Manager stated he was not given a specific date or time that the incident occurred. Through interviews it was thought the incident may have occurred up to a month prior. During interview Staff #1 and #7 both recalled the incident. Tenant #1 had been agitated during the evening hours and close to bedtime. Tenant #1 was reported to be yelling, raising the voice and using vulgar language. Tenant #1 was also reported to be raising night clothes and exposing self as no undergarments were in place. Tenant #1 was asked to go to the apartment to get undergarments. Tenant #1 refused and sat in a chair. Staff #1 pulled the chair to the apartment. The Manager reported the accounting of the incident by Staff #1 and #7 was consistent. The Manager reported both Staff #1 and #7 denied any wrongdoing. The Manager also reported Staff #1 and #7 had been separated from Tenant #1 by assigning them to the general population area.

The Manager reported Staff #1 and #7 both reported another staff member was present, Staff #2. The Manager stated there were no other reports of any other individuals present. The Manager stated he did not interview Staff #2.

Staff #7 was interviewed. Staff #7 identified herself as a Universal Worker who had been hired in March of 2014. Staff #7 reported she helped out in the dementia unit and worked 6:00 a.m. to 2:00 p.m. or 2:00 p.m. to 10:00 p.m. Staff #7 reported she had training to provide cares to tenants at the program and the training included how to care for tenants with dementia. Staff #7 reported if a tenant was agitated, the tenant would be redirected, she would try to get the tenant interested in another activity to get the tenant's mind of what was agitating them. Staff #7 stated if a tenant did not do what she wanted, she would let the tenant go and let them be, keeping an eye on the tenant to make sure the tenant was safe.

Staff #7 did not recall the date or month, but thought the incident occurred late in the day at bedtime. Staff #7 reported most all the tenants in the dementia unit were asleep. Staff #7 reported she came to work at 2:00 p.m. and worked in the dementia unit with Staff #2. Staff #1 was working in the general population area. Staff #7 reported Tenant #1 was walking in the halls between 9:30 p.m. and 10:00 p.m. Tenant #1 was being loud and was walking in the west hallway. Tenant #1's apartment was located in the east hallway of the dementia unit. Tenant #1 had lifted the night clothes up and Staff #7 could see that Tenant #1 was not wearing undergarments. Staff #7 stated she said to Tenant #1 that Tenant #1 might want to put down the night clothes because Tenant #1 was showing more than Tenant #1 might want to. According to Staff #7, Tenant #1 stated "I can show off any damn thing I want to" then brought the night clothes up further. Staff #7 stated "come on, you're waking up people" as three tenants were up. Staff #7 reported three tenants with dementia all came out of their apartments and watched Tenant #1. Staff #7 reported she walked to the central area of the dementia unit which had a sitting area. Staff #7 reported Tenant #1 followed as well as the three other tenants. Staff #7 reported trying to comfort the three tenants and the three tenants went back to bed. Staff #7 reported Staff #1 was not present at that time, and Staff #2 was sitting in the central sitting area.

Staff #7 reported Staff #1 came in, the three tenants were gone, and Tenant #1 sat on the couch. Staff #7 stated Tenant #1 accused Staff #1 of taking money. Tenant #1 was reported to say "if you would get off your fat ass, you might have something" or something similar. Staff #7 stated to Tenant #1 gruffly, "That's enough." Calling Tenant #1 by name, Staff #7 continued to say, "Go to your room." Staff #7 reported Tenant #1 did not go to the apartment, but stood there. Staff #7 sat down at a table and Tenant #1 came and sat at the same table. Staff #1 and #2 were present.

Staff #7 reported Staff #1 stated "let's take him/her for a ride." Staff #7 stated Tenant #1 was sitting in a dining room chair with arms and no wheels. Tenant #1 was taken for a ride down the hall to the apartment. Staff #7 stated Staff #1 started pushing and Staff #7 got up and helped. Staff #7 reported Tenant #1 was smiling, laughing, and swinging the feet, which did not touch the floor.

Staff #7 reported the apartment door was locked. Staff #7 asked Tenant #1,"What do you want to do, do you want to go for another ride?" According to Staff #7, Tenant #1 wanted to go to bed. Staff unlocked the door. Tenant #1 got up and went into the apartment, and shut the door. It was reported Tenant #1 liked the door shut and locked.

Staff #7 reported Tenant #1 was in the apartment, Staff #7 and #1 walked back to the sitting area where Staff #2 had been sitting the whole time.

Staff #7 reported the chair ride was done for fun and not in anger. Staff #7 reported it was a distraction to offer a ride, and the choice to offer the ride in the same hallway as Tenant #1's apartment was made because the other three tenants from the west hallway had just gotten back to bed.

Staff #7 reported she and Staff #2 were getting ready to leave at the end of their shift. Staff #7 gave report to Staff #1 who was working a double shift. Staff #7 and #1 went to check on Tenant #1 who was sound asleep in the bed.

Staff #1 was interviewed. Staff #1 identified herself as a Universal Worker hired 3-20-13. Staff #1 stated she had worked in the dementia unit, and worked all shifts. Staff #1 reported she was a Certified Nursing Assistant and had taken a medication manager course. Staff #1 reported she had annual dementia training on redirecting tenants, understanding the disease, understanding agitation and what is calming to tenants. For agitation, Staff #1 would redirect the tenant, and would get another staff member so the tenant would see a different face.

Staff #1 reported Tenant #1 had good days and bad, and was sometimes out of control. Tenant #1 has had medications adjusted.

Staff #1 reported she did not recall the date, but thought it was the month of May. Staff #1 thought the incident occurred in the evening after the evening medication pass, between the hours of 8:00 p.m. to 10:00 p.m.

Staff #1 reported she had come to work and was working in the general population. Staff #1 reported when work was completed in the general area, she would go help in the dementia unit. Staff #1 reported she was doing a medication pass in the general

area when she heard noise over the walkie-talkie. Staff #1 did not hear what was said, so she went to the dementia unit, about 8:30 p.m.

Staff #1 reported she walked through the main doors of the dementia unit and got to the kitchen and saw Tenant #1standing in the sitting area near the couches. Staff #1 reported there were four tenants sitting on the couches, including Tenant #2. Tenant #1 was agitated and stern, with fists clenched, hollering and yelling at other tenants. Tenant #1 was accusing the other tenants of being in Tenant #1's apartment. The other tenants were getting upset. Tenant #1 pulled the night clothes up and Staff #1 could see there were no undergarments. The other tenants were sitting there. Tenant #1 said to Tenant #2 "You can kiss my ass." Staff #1 reported Tenant #1 and #2 had gotten into an argument earlier over a baby doll. Staff #1 reported she had been in the dementia unit to assist with supper.

Staff #1 reported Staff #2 was sitting on the couch next to a tenant. Staff #7 was at the table in the sitting area folding laundry.

When Tenant #1 lifted the night clothes, Staff #1 reported she walked over to Tenant #1 and stated "Let's not show everyone what you've got." Tenant #1 eventually put down the night clothes. Staff #1 walked into the kitchen to get a glass of juice, and Tenant #1 followed. Tenant #1 was reported to be yelling the whole time. Staff #1 ignored Tenant #1's comments, and said "Let's be nice."

Staff #1 was standing, Tenant #1 was sitting at the table where Staff #7 was folding clothes. Staff #2 was still sitting with the tenants on the couch. Tenant #1 moved the chair to be able to see Tenant #2. Tenant #1 and Tenant #2 "got into it." Staff #7 said gruffly, "Go to your room," referring to Tenant #1. Tenant #1 responded with profanity. Tenant #2 came up and jumped to staff's defense according to Staff #1. Tenants #1 and #2 were face-to-face and Tenant #1 grabbed Tenant #2's shirt. Staff #1 reported she got between the two tenants to separate them. Staff #7 put a hand on Tenant #2's back to redirect, but Tenant #2 came back. Tenant #1 continued to sit in the chair yelling profanities.

According to Staff #1, she said to Tenant #1, "Come on, let's go to your room." Tenant #1 replied "OK." Staff #1 pulled Tenant #1 down the hall in the chair. Tenant #1 lifted the feet and did not disagree. Staff #1 said, "OK, let's go." Tenant #1 seemed to have fun and said "Whee" all the way down the hall. Staff #1 stated Tenant #1 did not like to be touched, so Staff #1 tried to think quickly; it was not a punishment and not done in anger. Staff #1 stated she was trying to defuse the situation without two tenants getting hurt.

Staff #1 stated she held the back of the chair, and Staff #7 had her hands on the arms of the chair. Staff #1 started to pull the chair backwards, then turned the chair around so Tenant #1 could see where they were going.

The apartment was locked. Staff #1 reported Tenant #1 always kept the apartment locked. Staff #1 unlocked the apartment. Tenant #1 stood up and said "Thank you," and shut the door. Staff #1 reported she checked on Tenant #1 later, and Tenant #1 was in bed.

Staff #1 reported the chair slid easily. Staff #1 took the chair back to the sitting area and checked on the other tenants. Staff #1 stated she returned to the general population area.

Staff #2 was interviewed. Staff #2 reported the incident occurred on May 29th. A review of time cards for Staff #1, #2, and #7 indicated all were working hours during the evening shift on 5-29-14.

Staff #2 was working from 2:00 p.m. to 10:00 p.m. in the dementia unit. On May 29th, Staff #2 had passed medications and estimated the time to be about 9:00 p.m. Tenant #1 did not want to sleep, and left the apartment to walk in the hallway. Staff #2 reported she was working with Staff #7 and Staff #1 came over to talk to Staff #7. Staff #2 stated she was not sure why Staff #1 and #7 wanted Tenant #1 to go to bed. Staff #2 reported Tenant #1 was grouchy, which was usual for Tenant #1.

Staff #2 reported Tenant #1 was walking and Staff #7 stated to Tenant #1 "Go to bed." Tenant #1 said "No," and tried to sit down in the chair. Staff #2 stated Tenant #1 sat voluntarily in the chair and was not pushed to sit down. Tenant #1 was reported to be using "bad words" according to Staff #2. Staff #7 screamed at Tenant #1 "Go to bed," and referring to the bad words, "It's inappropriate." Tenant #1 sat down. Staff #2 reported Tenant #1 used the word "bitch."

According to Staff #2, Staff #1 said to grab the chair. Staff #2 reported she was sitting on the couch. Staff #2 reported Staff #7 was at the front of the chair and Staff #1 was behind the chair. Staff #2 reported Staff #7 and #1 were laughing Both Staff #7 and #1 grabbed the chair and pulled the chair to Tenant #1's apartment. Tenant #1 stood up, and the lights were shut off and the door was pulled shut while Tenant #1 was still talking.

Video provided to the department revealed what appeared to be the dementia unit. There were two staff members standing and a tenant who was standing and went to sitting in a chair at a table. The first staff member, Staff A, yelled "You are not sitting down there, I am using that!" At that time, Staff A, the staff member to the left of the video screen approached the tenant and said "Get in there" and pointed to the right of the video screen. At that time, the other staff member, Staff B, stated "I'll just grab his/her chair" and proceeded to the back of the chair and pulled the chair to the right of the screen, which would be to the east hallway of the dementia unit. Laughter was heard. Staff B stated "Come on, let's go, come on." The tenant was not heard to make any statements.

Based on the statements given by Staff #1, #2, and #7, the Department concluded Staff A was Staff #7 and Staff B was Staff #1. The tenant would be Tenant #1.

During the video, Tenant #1 was not observed to be physically aggressive. Tenant #1 was not yelling or using a loud voice.

The video showed that Tenant #1 was taken in the chair down the hall to the apartment by Staff #1 and #7. Tenant #1 had the back facing the direction the chair was moving. It appeared that one or both feet were dragging on the floor at times.

The video showed that upon reaching the apartment door, the chair was turned to face the apartment door. Either Staff #1 or #7 was heard to say "Go on, get in there, right now." Tenant #1 was heard to say "I don't really want to." Either Staff #1 or #7 then went on to say, "then you shouldn't talk to people like you do." "Let's just arm him/her." The other staff member stated, "I don't know what that means," to which was replied "one of us under each arm, carry him/her off..." The chair containing Tenant #1 was turned around by Staff #7 and the chair was pulled backward into the apartment. Tenant #1 was told "Keep your butt in here. Until you can talk civil." Staff #7 and #1 left the apartment, shut off the lights and shut the door.

Tenant #1, who was cognitively impaired and resided in the dementia unit, was not treated with respect when yelled at, when taken in a stationary chair and pulled backwards with foot/feet dragging to the apartment.

Tenant #1 verbalized that entering the apartment was not what was desired. The chair was turned, there was a discussion of "arming" Tenant #1, and Tenant #1 was pulled into the apartment in the chair. The lights were turned off and the door was shut.

Tenant #1 was not treated with consideration, respect, and recognition of autonomy.

Staff #1 and #7 verbalized understanding of care of a person with dementia including the use of redirection and letting a tenant "be" as long as the tenant was safe. Tenant #1 did not receive appropriate services in this instance.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

- Regulatory Insufficiency: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

**B. Other**

Complaint/Incident Allegation: It was alleged administrative policies related to employment were not followed.

- Monitoring Observation: Employee personnel files were reviewed for eight staff members, #1, #2, #3, #4, #5, #6, #7, and #8. Four staff members were current employees; four were no longer employed by the program. No issues were identified with background checks, dementia or food safety training, mandatory dependent adult abuse training, or delegation of tenant care tasks as appropriate.

  The program did not provide complete documentation of scheduled work hours for the previous 90 days. Shifts for the direct care staff were identified as 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m., and 10:00 p.m. to 6:00 a.m. Documentation of time cards was provided from March 1, 2014 to the present for staff #1, #2, #3, #4, #5, #6, #7, and #8.

Two former employees were direct care staff, #2 and #8. Using the standard shift start times and the program's expectation that staff members were to punch into work on or before the scheduled beginning of the shift, Staff #2 was late to work 37 of 44 days worked. Staff #2 was hired 4-14-14. On 4-20-14, Staff #2 received a written warning for tardiness. Staff #2 also received verbal warnings on 5-17 and 6-6-14 for tardiness.

Staff #8 was hired on 4-14-14 and was late to work five of 34 days. Staff #8's employee file contained no documentation of any warnings related to tardiness.

The Manager was interviewed and stated he had received complaints from other staff members which indicated Staff #2's tardiness had affected others. The Manager reported he had not received such complaints about any other staff member.

Staff #9 and #10 were interviewed. Both stated the flow of work and schedules were disrupted by the tardiness of Staff #2. Both stated while other staff members may be late it has not affected work and has not affected them personally.

A review of the employee handbook identified employment at the program was "at will" which meant employment was of no specific length. The program or the employee could discontinue employment at any time for any reason.

Tardiness was defined as failure to punch into work on or before the scheduled beginning of the shift.

The employee handbook also identified corrective action was taken when an employee was not acting in the best interest of the tenants, fellow employees, or the program. Corrective action may include verbal or written warnings, suspension or termination. The program also reserved the right to choose the level of corrective action.

There was no evidence to suggest administrative policies related to employment were not followed.

- Regulatory Insufficiency: None noted.