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 #: 50378-I

October 31, 2014

Ms. Emily Miller, Director
Lakeview Lodge Assisted Living
312 Southbrooke Drive
Waterloo, IA 50702

RE: Final Complaint/Incident Investigation Report – Lakeview Lodge Assisted Living, Waterloo, IA

Dear Ms. Miller:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 20, 21 and 30, 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:

Emily Miller, Director
Lakeview Lodge Assisted Living
312 Southbrooke Drive
Waterloo, IA 50702

Complaint/Incident Intake #: 50378-I

Date of Complaint/Incident Investigation:

October 20, 21, and 30, 2014

Monitor(s):

Lori Miner, RN BSN
Wendy Kuhse, RN

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 Dedication	
Number of tenants without cognitive disorder:	10
Number of tenants with cognitive disorder:	35
Total Population of Program at time of on-site	45
TOTAL census of Assisted Living Program	45

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

A. Staffing

Complaint/Incident Allegation: The program reported an incident where staff observed a tenant engaging in sexual contact with a visitor. The visitor was identified as being on the sex offender registry.

- Monitoring Observation: At approximately 9:30 am on 10-11-14 the buzzer went off at the front door. Staff #1 opened the door and a visitor walked in, asking to see Tenant #1. On the way in the visitor spoke with Staff #2. A short time later Staff #3 stated she knocked on the door of Tenant #1's apartment, got no response, and entered the apartment to see the visitor standing with the back to the door. Tenant #1 was observed pulling down the shirt and seeming nervous. Staff #3 asked Tenant #1 if Tenant #1 was ok. Tenant #1 indicated yes.

  Staff #3 then notified Staff #4 that Staff #3 was not comfortable with what she observed in Tenant #1's apartment. Staff #4 got some water cups to restock Tenant #1's apartment. Staff #4 went to Tenant #1's apartment, knocked on the door, then entered. Staff #4 observed the visitor sitting in the chair with the back to the door. Tenant #1 was standing in front of the visitor pulling down Tenant #1's shirt. The visitor did not speak when Staff #4 entered the apartment.

  Staff #4 left the apartment but left the door partially open and observed the visitor with the back to the door spreading legs apart and making motions to unzip pants. Tenant #1 then walked towards the visitor, kissed the visitor, and reached to the area of the visitor's pants. The visitor was observed moving shoulders as if to touch Tenant #1.

  Staff #4 left in a hurry and thought the visitor knew someone was watching. None of the staff recalled seeing the visitor at the program before. It was recalled the visitor

had recognized Staff #2. Staff #2 reported she had known the visitor since childhood. Staff relayed to Staff #2 the incident that occurred. At that moment, Staff #2 recalled hearing as a child the visitor was alleged to have inappropriate contact with someone in a nursing home. Staff #2 reported she believed from childhood that the visitor was innocent of any charges.

Staff #5 notified the Director, who began an internal investigation and notified the police. The visitor was listed on the sex abuse registry.

Tenant #1, 72 year-old, was admitted on 10-4-13 and had diagnoses of: Dementia, Gastroesophageal Reflux Disease, and Osteoporosis. Tenant #1 was staged at five on the Global Deterioration Scale which indicated moderate dementia.

The police arrived and the Director was present for the interview with Tenant #1. Tenant #1 reported having a visitor, someone Tenant #1 had known for a long time.

The police arrived and interviewed Tenant #1 with the Director present. Tenant #1 reported knowing the visitor for a long time.

In an interview with the officer, he reported notifying the visitor it was not permissible to return to the program.

The family of Tenant #1 was notified and reported the visitor was a long-time family friend. The family was not aware the relationship between Tenant #1 and the visitor was anything more than friendship. The family was aware the visitor was alleged to have inappropriate behavior with another adult, but did not believe the allegations were true.

The program took immediate action once the incident occurred including an internal investigation, and police and family notification. The visitor was no longer welcome at the program and staff members were instructed to ask the visitor to leave if seen again, and security would be called. The program was instituting a log book for visitors to sign in and out.

Staff members at the program did not recall seeing the visitor at the program prior to 10-11-14 and the program had no prior knowledge of the visitor's history. The visitor has been restricted from future visits. An internal investigation was completed, the police and family were notified. Staff members were instructed to watch for the visitor, and ask the visitor to leave if seen again. A log book for visitors to sign was being instituted.

- Regulatory Insufficiency: None noted