IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
60677-C
60687-C

July 5, 2016

Mr. Ted Gorter, Manager
Parker Place Retirement
707 Hwy 57
Parkersburg, IA 50665

RE: Final Complaint/Incident Investigation Report, Parker Place Retirement, Parkersburg, Iowa

Dear Mr. Gorter:

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 **June 22, 2016.**

Comments: Two complaints were filed with the Department. The areas identified in the complaints included: Service Plans, Level of Care and Staffing. In the areas of Service Plans and Staffing, a review of information resulted with no concerns. In the area of Level of Care, the Department finds that two tenants exceed Level of Care.

The Department also found that tenant rights had been violated. Tenants who resided in the memory care unit were exposed to strong smell of urine due to another tenant's behavior. Tenants who resided on the general population unit were exposed to offensive sexually aggressive behaviors exhibited by a tenant.

During the course of the investigation, the Department identified a concern regarding the information being provided by staff and the incident reports provided by the Program. The Program utilized electronic records in conjunction with written documentation completed by staff. Based on interviews, the written documentation was input into the electronic record by the Health Care Coordinator. The Department's legal counsel reviewed the practice and

determined the input into the electronic record may be continued, but the Program must retain a copy of the original documentation from this point forward.

The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights and Criteria for Admission/Retention of Tenants.

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,

Linda Kellen, Bureau Chief
Adult Services/Special Services

Rose Boccella

Rose Boccella, Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: _____ B. WING _____	C 06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 12 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 13 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 23 The following regulatory insufficiencies were cited during the investigation of Complaints 60677-C and 60687-C :	A 000		
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by:	A 012		

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A 012	Continued From page 1 Based on observations and interviews, the Program failed to ensure tenants were treated with consideration, respect, personal dignity and autonomy. All tenants were potentially affected. 1. Tenant #1, a 95 year-old, was admitted on 3-19-12 and had diagnoses of: unspecified dementia without behavioral disorder, anxiety disorder unspecified, diabetes, insomnia, hypertension, atrial fibrillation and chronic obstructive pulmonary disease. Tenant #1 was staged at six on the Global Deterioration Scale which indicated severe cognitive decline. Tenant #1 resided in the dementia/memory care unit. 2. Interviews with six staff (Staff A, B, C, D, E and F) revealed Tenant #1 had been urinating inappropriately throughout the memory care unit. Staff B, D and E, mentioned Tenant #1 urinated in the heat/air conditioning units in Tenant #1's apartment and other tenants' apartments if they left the doors unlocked. During a visit to the memory care unit on 6/15/16, a strong urine odor was present in the hallway. During another visit to Tenant #1's apartment on 6/20/16, Staff D and E explained they had the windows open to help with the strong odor. Observations revealed a very strong urine odor. Staff explained they opened the windows to attempt to lessen the smell in the apartment. 3. Program Documents include the following: on 6/13/16, Tenant #1 was urinating on the living room carpet. Tenant #1 also stopped by another tenant's door and urinated on the carpet. On 5/12/16, Tenant #1 urinated and defecated in a baby cradle. It was documented that Tenant #1 does this often. 4. Tenant #2, a 49 year-old, was admitted on	A 012		

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A 012	Continued From page 2 4-26-14 and had diagnoses of: unspecified dementia without behavioral disorder, bipolar disorder, major depressive disorder single episode, Parkinson's disease, insomnia, hypertension and gastro-esophageal reflux. Tenant #2 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline. Tenant #2 resided in general population assisted living. 5. Interviews with six staff (Staff A, C, F, G, H and I) revealed tenants who reside in the general population of the building are concerned about Tenant #2's behavior. According to interviews, Tenant #2 displays inappropriate behaviors which includes public masturbation and aggressive episodes toward staff. Staff reported tenants are afraid and concerned about Tenant #2's behavior and most will not use the courtyard because Tenant #2 has been found to be masturbating in the courtyard on several occasions. 6. Review of incident reports and progress notes from 3/15/16 through 6/20/16, revealed at least eight entries documenting Tenant #2's behavior including the following: laying face down on the sidewalk with shorts and underwear below knees, masturbating in wheelchair in the courtyard, swinging and hitting a staff member, "cussing" and yelling at staff, pounding on door, raising walker overhead as if to throw it at staff, close to running into tenants, visitors and staff as the result of not using walker and shuffling at a fast pace and masturbating in the courtyard while sitting at a table. 7. Three tenants were interviewed regarding # Tenant 2's behavior. When interviewed on 6/21/16, Tenant #7 said	A 012		

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A 012	Continued From page 3 Tenant #2 moves around the Program quickly and scares others. Tenant #7 is concerned for Tenant #2 and worries constantly that Tenant #2 will fall and/or hurt others. Tenant #2 almost knocked down another tenant in the hallway. Tenant #7 chooses not to use the courtyard because Tenant #2 spends much of the time out there. On 6/22/16, Tenant #7 approached the monitor, was noticeably upset and said Tenant #2 was disrupting the activity so Tenant #7 choose to leave the activity. Tenant #8 explained that Tenant #2 can be frightening and when meeting Tenant #2 in the hallway it's necessary to get near the wall and possibly look for something to hang on to because of being afraid of being knocked down. According to Tenant #8, "Tenant #2 is unpredictable and I never know if ... will attack me." Tenant #8 also said, "I am glad ... lives on the other hallway." Tenant #8 does not use the courtyard because Tenant #2 spends much of the time in the courtyard. Tenant #9 said Tenant #2 will not follow staff directions and noted this is particularly frustrating in the dining room when Tenant #2 gets up and moves around with dishes and often drops and breaks them. Tenant #9 said Tenant #2 was laying outside naked and Tenant #9 would not use the courtyard because of Tenant #2's behavior.	A 012		
A 040	481-69.23(1)c(1) Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted	A 040		

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A 040	Continued From page 4 or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on tenant file reviews and staff interviews, the Program failed to discharge a tenant who exceeded the criteria for admission and retention. Despite intervention, the tenant was sexually and physically abusive. (Tenant #2). 1. Tenant #2, a 49 year-old, was admitted on 4-26-14 and had diagnoses of: unspecified dementia without behavioral disorder, bipolar disorder, major depressive disorder single episode, Parkinson's disease, insomnia, hypertension and gastro-esophageal reflux. Tenant #2 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline. Tenant #2 resided in general population assisted living. Incident reports and progress notes documented the following regarding Tenant #2's behavior: a. On 3/15/16, office staff observed Tenant #2 laying face down at the west end of the sidewalk in the courtyard. Tenant #2's shorts and underwear were below his/her knees. When staff asked Tenant #2 what he/she was doing, Tenant #2's response was picking weeds. When asked how his/her pants got around his/her knees, Tenant #2's reply was when he/she was getting on the ground they fell down. Tenant #2 wasn't	A 040		

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A 040	Continued From page 5 concerned about his/her pants being around his/her knees. Staff walked to Tenant #2's apartment as Tenant #2 ran to apartment with his/her walker. Staff talked with Tenant #2 about the consequences of action and the possibility of having to leave Parker Place. Doctor notified. b. On 4/22/16, management staff were summoned by other staff members. Tenant #2 had been masturbating in his/her wheelchair in the courtyard. Management staff approached the area and witnessed the activity. The Manager approached Tenant #2 and Tenant #2 quit immediately. Counseling was given on the appropriate places where Tenant #2 is able masturbate such as in Tenant #2's apartment and not in public places. The Manager notified parent and initiated a corrective action plan for the next 30 days as this activity has occurred several times in the past as well. c. 5/12/16, staff entered the workroom to give report to each other and found Tenant #2 in the workroom getting cigarettes out of the drawer. Staff took them away and said Tenant #2 would have to wait a moment and asked Tenant #2 to leave the room. Tenant #2 refused to leave and was swinging at staff and hit one staff member in the arm. Tenant #2 was also "cussing" and yelling. Staff were able to remove Tenant #2 from the workroom. Tenant #2 then pounded on the door for several minutes. d. On 5/13/16, Tenant continues to become upset with staff when they are not able to get Tenant #2 a cigarette immediately after asking for one. Staff are to remind Tenant #2, that Tenant #2 must be pleasant, cooperative and patient and this seems to lessen issues.	A 040		

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A 040	Continued From page 6 e. On 5/15/16, staff reported that Tenant #2 had asked for a cigarette and when staff was going to get one, Tenant #2 started "cussing" at the universal worker and spit on her. Physician and family made aware. f. On 5/16/16, Tenant #2 became verbally and physically aggressive with kitchen staff. Tenant #2 raised Tenant #2's walker over his/her head as if Tenant #2 was going to throw it at staff or hit staff with it. Tenant #2 was yelling at both staff and "cussing", calling them worthless and so forth. Parents made aware of situation and physician notified as well. g. On 6/9/16, staff and other tenants expressed some concerns related to their safety as well as Tenant #2's safety. Tenant #2 often forgets to ambulate with his/her walker. Tenant #2's gait is shuffled and usually at a fast pace. Tenant #2 has came close to running into other tenants, staff and visitors. h. On 6/20/16, Tenant #2 was masturbating in the courtyard while sitting in a chair at a table after staff has assisted Tenant #2 outside to smoke a cigarette. Program began a corrective action to be reviewed with Tenant #2 regarding such incidents. Interviews with six staff (Staff A, C, F, G, H and I) revealed tenants, who resided in the general population of the building, and are concerned about Tenant #2's behavior. According to interviews, Tenant #2 displays inappropriate behaviors which include public masturbation and aggressive episodes toward staff. Staff reported tenants are afraid/concerned about Tenant #2's behavior and most will not use the courtyard because Tenant #2 has been found to be	A 040		

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A 040	Continued From page 7 masturbating in the courtyard on several occasions.	A 040		
A 223	481-69.23(1)j Criteria for Admission/retention of Tenants j. Despite intervention, chronically urinates or defecates in places that are not considered acceptable according to societal norms, such as on the floor or in a potted plant. This REQUIREMENT is not met as evidenced by: Based on tenant file reviews and staff interviews, the Program failed to discharge a tenant who exceeded the criteria for admission and retention. A tenant, who despite intervention, chronically urinated/defecated in unacceptable places according to societal norms (Tenant #1). 1. Tenant #1, a 95 year-old, was admitted on 3-19-12 and had diagnoses of: unspecified dementia without behavioral disorder, anxiety disorder unspecified, diabetes, insomnia, hypertension, atrial fibrillation and chronic obstructive pulmonary disease. Tenant #1 was staged at six on the Global Deterioration Scale which indicated severe cognitive decline. Tenant #1 resided in the dementia/memory care unit. Review of Progress Notes revealed the following entries: b. On 5/12/16, a note documented Staff reported seeing Tenant #1 in the memory care. When they approached, Tenant #1 was noted to be defecating and urinating in a baby cradle. Tenant #1 was cleaned and redirected back to his/her apartment. Staff reported Tenant #1 does this	A 223		

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A 223	Continued From page 8 often. An alarm was placed on the Tenant's door to alert staff when Tenant #1 is out of the apartment, so they are able to offer toileting. c. On 6/13/16, an Incident Report documented that Tenant #1 was wandering the halls and stopped by another tenant's door and urinated on the carpet. a. On 6/13/16, Tenant #2 was walking around in the Parker Place Gardens and had stopped in the living room and began urinating on the carpet in the living room area. Interviews with six staff (Staff A, B, C, D, E and F) revealed Tenant #1 had been urinating inappropriately throughout the memory care unit. Staff mentioned Tenant #1 urinated in the heat/air conditioning units in Tenant #1's apartment and other tenants' apartments, if they left the doors unlocked. During a visit to the memory care unit on 6/15/16, a strong urine odor was present in the hallway. During another visit to Tenant #1's apartment on 6/20/16, staff explained they had the windows open to help with the strong odor. Observations revealed a very strong urine odor. Staff explained they opened the windows to attempt to lessen the smell in the apartment.	A 223		