IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT GOVERNOR

DEAN A. LERNER, DIRECTOR

May 12, 2009

**Complaint #23250-C**

Stephen King, Administrator
The Rose of Ames
1315 Coconino Rd
Ames, IA 50014-8035

**RE: Complaint Investigation Report, Rose of Ames, Ames, IA**

Dear Mr King:

Enclosed is the **Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with the Code of Iowa, section 231C.7, Iowa Administrative Code, chapter 25, pertaining to assisted living programs and, chapter 26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

A copy of the monitor's **Complaint Investigation Report** is enclosed for your information and as a record of the result of this investigation.

If you have any questions regarding this Report, please contact me at 515-281-5003

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau

Enclosure

# Iowa Department of Inspections and Appeals
# Assisted Living Program
# Final Complaint Investigation Report

**Assisted Living Program:** **Complaint Intake #: 23250-C**

Stephen King, Administrator
The Rose of Ames
1315 Coconino Rd
Ames, IA 50014-8035

**Date of Investigation:**

May 1, 2009

**Monitor(s):**

Vickie G. Clingan, RN, MA

**Definitions:**

The following definitions are relevant:

**Regulatory Insufficiency** - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

**Dementia-specific assisted living program** - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

**Overview:**

A complaint investigation on-site visit was conducted at The Rose of Ames on May 1, 2009 In preparing this report, the following information was considered:

**Current Program Census:**

***General Population Program (GPP)**** – A program that is not a Dementia Specific program but may have tenants with cognitive disorder

| | |
|---|---|
| Current number of tenants without cognitive disorder: | 57 |
| Current number of tenants with cognitive disorder: | 0 |
| Total Population: | 57 |

***Dementia Specific Program (DSP)**** – Not applicable.

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

**Program History** – The program has had a substantiated Regulatory Insufficiency in the area of Life Safety

**Complaint Investigation** – The complaint investigator(s) made the observations detailed in the following areas.

**A. Criteria for exclusion of tenants** - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation: It was alleged a tenant left skilled care and returned to his/her apartment against medical advice. It was also alleged the tenant's apartment contained bags of garbage and boxes, making it difficult to walk in the apartment and the tenant had fallen many times. The tenant had refused all services and refused to let anyone but the social worker into the apartment. It was also alleged the tenant was noncompliant with all interventions and he/she was not completing personal cares, such as bathing.

- Monitoring Observation: Tenant #1, a 59 year old, was admitted to the program on 5/22/05 with diagnoses of Multiple Sclerosis since 1994, and depression.
  The Coordination of Care Note dated 4/28/09 described Tenant #1 as having abrasions on both forearms and bandages on both knees. The tenant was extremely unsteady, leaning to side and back. He/she needed to hold on to the walls, counters and furniture to be steadier with walking. When the tenant walked into the bedroom without a walker, the tenant fell on the bed after letting go of the wall. The apartment appeared in an unsanitary and unsafe condition with many boxes, items, bags of trash strewn about, and piles of mail on the floor When the tenant lifted the walker over a bag and became stuck, the tenant required assistance to get completely over the bag. According to the same note, the tenant's speech was slurred, making it difficult to understand what the tenant was saying. The tenant expressed extreme fatigue, displayed tearfulness and expressed anger and frustration. The same note explained the tenant admitted falling multiple times since returning to the apartment (April 27, 2009) from a skilled care facility

  On 5-1-09 at approximately 9:30 am, the monitor attempted to visit Tenant #1, however, he/she refused and did not open the apartment door Although the tenant was predisposed to falls due to an unsafe environment, the tenant did not exceed level of care at the time of this investigation.

- Regulatory Insufficiency: None noted.

**B. Program Initiated Involuntary Transfer** – Program initiates the involuntary transfer of a tenant and the action is not a result of a monitoring evaluation or complaint investigation by DIA. [321 IAC 25.26(1)]

Complaint Allegation: It was alleged a tenant left skilled care and returned to his/her apartment against medical advice. It was also alleged the tenant's apartment contained bags of garbage and boxes, making it difficult to walk in the apartment and the tenant had fallen many times. The tenant had refused all services and refused to let anyone but the social worker into the apartment. It was also alleged the tenant was noncompliant with all interventions and he/she was not completing personal cares, such as bathing. It was also alleged the program gave the tenant a 3 day eviction notice and the tenant didn't plan on doing anything on the day he/she was to move out.

- Monitoring Observation: According to the Coordination of Care Note dated 4/28/09, the program informed Tenant #1 of all the available options. The tenant could return to the skilled nursing facility, or remain at the program and accept needed services to sustain the tenant's health and well-being. The program also suggested the tenant could move to his/her mother's house. The tenant refused the options. The program issued an eviction notice on 4-27-09 and the tenant was in the process of moving on May 1, 2009

- Regulatory Insufficiency: None noted.

Dated this 12th day of May, 2009