IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 35218-I

September 2, 2011

Vicki Truby, Administrator
Rose of East Des Moines Assisted Living
1331 Idaho Street
Des Moines, IA 50316

RE: Final Incident Investigation Report – Rose of East Des Moines Assisted Living, Des Moines, IA

Dear Ms. Truby:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of August 23, 2011, 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.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #:** 35218-I

Vicki Truby, Administrator
Rose of East Des Moines Assisted Living
1331 Idaho Street
Des Moines, IA 50316

Date of Incident Investigation:

August 23, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

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. IAC r. 481-67.10(5). 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 an Incident 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 481 IAC - chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Rose of East Des Moines Assisted Living on August 23, 2011. 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:	70
Current number of tenants with cognitive disorder:	0
Total Population:	70

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 received regulatory insufficiencies during the Recertification on site visit of January 10 and 12, 2011, in the areas of service plan and staffing.

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

A. Structural requirements

Incident Allegation: The program reported Tenant #1 was on the back patio and tripped over cable used to secure a table and chair to the patio. The cable was used to secure both from theft.

- Monitoring Observation: Tenant #1, (the Tenant) a 72 year old, was admitted on on 2-27-09 and had diagnoses of: Hypertension, a history of C-5-C-6 Fracture and Bilateral Humeral Fracture. A cognitive evaluation was completed on 6-10-11 and indicated the Tenant had normal cognition. A functional evaluation of 6-10-11 revealed the Tenant was independent with ambulation.

  Program documentation revealed on 7-21-11, the Tenant and a family member were on the southwest patio. When the Tenant stood to leave he/she caught her foot on the cable attached to the table and chair. The Tenant was taken by ambulance to a local hospital emergency room. The Tenant was admitted to the hospital with an admitting diagnosis of C-5-C6 Compression Fracture and Bilateral Broken Arms. Program documentation revealed the Tenant returned to the program on 8-16-11. The program completed functional and health evaluations, a service plan update on 8-16-11. The service plan revealed the Tenant was receiving assistance from family with bathing and personal cares and was independent with ambulation. A cognitive evaluation of 8-16-11 revealed normal cognitive function.

  The Nurse reported the Tenant had no cognitive issues, was independent with activities of daily living (ADLs), including ambulation and had no history of falls. No other tenants have tripped over or had fallen due to cables attached to chair and benches. Program documentation and interviews with the Administrator revealed cables used to attach the furniture were put in place during construction and had been

in place when the program initially opened. The cables have since been removed from all patio furniture.

- Regulatory Insufficiency: None noted.

Dated this 2nd of September, 2011.