IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 35051-C

October 4, 2011

Ms. Susan Bowen, Executive Director
Primrose Retirement Community
1801 East Kanesville Blvd.
Council Bluffs, IA 51503

RE: Final Complaint/Incident Investigation Report – Primrose Retirement Community, Council Bluffs, IA

Dear Ms. Bowen:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 27 and 28, 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 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Susan Bowen, Executive Director
Primrose Retirement Community
1801 East Kanesville Blvd.
Council Bluffs, Iowa 51503

Complaint/Incident Intake #:

35051-C

Date of Complaint/Incident Investigation:

September 27 and 28, 2011

Monitor(s):

Maribeth Freland 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.

General Population Program	
Number of tenants without cognitive disorder:	29
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	33

Program History – There were no regulatory insufficiencies found during this certification period.

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

Structural Requirements

Complaint/Incident Allegation: It was alleged the entrance door to the assisted living was inoperable for an extended period of time and too heavy for a lot of tenants to open manually. It was alleged the other handicapped exit was too far for most tenants to walk. It was alleged the sidewalk outside of the assisted living entrance was in need of repair for an extended period of time, causing people to fall.

- Monitoring Observation: At initiation of the complaint investigation, the monitor noted the sidewalk outside the assisted living entrance showed evidence of six newly replaced light gray concrete panels, each measuring approximately five foot by five foot. The monitor noted a painted yellow stripe on the concrete panel directly in front of the new sidewalk panels when leaving the building. Two orange cones were sitting up next to the building. The ground area to the right of the entrance door appeared to be newly cultivated and seeded.

  The Executive Director reported the drain spouts next to the assisted living entrance had been draining too close to the building, causing the water to seep under the sidewalk panels. In January 2011, the water froze causing the middle panel directly in front of the door to heave, raising one end up by approximately one inch. The program immediately painted a yellow stripe on the adjoining panel to the raised end of the affected panel and placed an orange cone to each side of the panel.

  The monitor reviewed incident reports from January 2011 through September 2011, finding no tenant falls or injuries caused by the sidewalk issues. The monitor noted one incident report, dated 1-29-11, documenting a visitor tripped on the raised sidewalk. The Executive Director reported a visitor caught his/her toe on the raised area of the sidewalk panel, tripped and fell on 1-29-11.

The visitor fell to his/her knees, causing one knee to swell and bruise. The visitor sought medical evaluation with no fractures noted. The monitor contacted the visitor by telephone. The visitor reported he/she visited the program on a routine daily basis and was aware of the raised sidewalk panel. The visitor reported he/she was carrying items that obstructed his/her view at the time of the fall. The visitor reported seeking medical evaluation with only bruising and swelling to his/her knee noted.

The Executive Director reported the affected concrete sidewalk panel was removed after the visitor fell and a panel of plywood was placed into the existing hole to remove the potential for others tripping on the raised panel. Due to the winter conditions, the sidewalk remained this way until the ground thawed and work on the drainage system could begin. The program had the drain spouts averted into an underground drainage system to alleviate the collection of the water under the sidewalk and had five other panels of the sidewalk area removed. The program replaced the six panels with new concrete, resulting in a flat, safe surface. All repairs were complete on 8-31-11. City officials were involved during the entire process.

The Executive Director reported the building had an alternate handicapped access available for tenant use while awaiting sidewalk repairs. The handicapped entrance of the independent living area is 184 feet from the entrance to the assisted living area. The assisted living area also has two single door exits that are approximately 50 feet on each side of the handicapped exit.

Upon initiation of the complaint investigation, the monitor tested the handicapped doors at the assisted living entrance and the independent living entrance. Both entrance doors worked appropriately when used to enter and exit each door. The Executive Director reported the assisted living entrance door had experienced need for repairs since January 2011.

The Maintenance Manager's work order requests showed the following:

Date	Problem	Action Taken	Date Completed
1-5-11	Handicapped button not working.	ELS board replaced on power assisted opener.	1-22-11 by door closure company.
1-30-11	Interior door not opening all the way.	Door retrained electronically.	2-1-11 by Maintenance Manager.
2-11-11	Outside handicapped button not working.	Door opener reset	2-14-11 by Maintenance Manager.
3-23-11	Handicapped door randomly opens by self and shuts really hard.	Contacted door closure company.	Tried different things; none working. Door still worked but opens on own sporadically.

3-31-11	Handicapped door will not close.	Contacted door closure company.	Replaced entire door closure by door closure company 4-2-11.
4-7-11	Outside handicapped button not working.	Turned switch to on. Doors switches shut off during night- not turned back on.	4-7-11 by Maintenance Manager.

- Regulatory Insufficiency: None noted.

Dated this 29th day of September 2011.