IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 38661-C

June 5, 2012

Ms. Vicki Truby, Administrator
Rose of East Des Moines
1331 Idaho Street
Des Moines, IA 50316

RE: Final Complaint/Incident Investigation Report, Rose of East Des Moines, Des Moines, Iowa

Dear Ms. Truby:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

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,

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:

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

Complaint/Incident Intake #:

#38661-C

Date of Complaint/Incident Investigation:

April 30, and May 1, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix 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:	65
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	66
TOTAL census of Assisted Living Program	66

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.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged that tenant's are afraid of staff members and that staff members yell at tenants, mock them and treat them unkindly. It was also alleged suspicious bruising was found on a tenant.

- Monitoring Observation : The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and conducted interviews with Tenants #2, #3, #5, #7, and #10.

  Tenant #1, an 86 year old, was admitted 6-17-09 with diagnoses of Hypertension (HTN) and History of Stroke. The Global Deterioration Scale (GDS) of 3-27-12 scored the Tenant at a 3 which indicated mild cognitive decline. The monitors attempted to interview Tenant #1 multiple times and were unable to make the contact.

  Tenant #2, a 92 year old, was admitted 5-27-10 with diagnoses of: HTN, Asthma, and Arthropathy. The cognitive assessment dated 4-3-12 indicated Tenant #2 had little or no cognitive impairment. Tenant #2 reported kind treatment and no fear of staff members except for an occasional loud response.

  Tenant #3, an 82 year old, was admitted 1-30-09 with diagnoses of HTN and Cerebral Vascular Accident. The cognitive assessment dated 3-20-12 indicated Tenant #3 had little or no cognitive impairment. Tenant #3 reported kind treatment from staff members and no fear of staff and except for an occasional impatient response.

Tenant #4, a 91 year old, was admitted 6-17-09 with diagnoses of Arthritis and Dementia. The GDS of 3-12-12 scored 4 which indicated moderate cognitive decline. Tenant #4 no longer resided at the program.

Tenant #5, an 82 year old, was admitted 10-29-08 with diagnoses of: HTN, Arthritis, Fibromyalgia, and Chronic Fatigue. The program's cognitive assessment dated 4-27-12 indicated Tenant #5 had little or no cognitive impairment. Tenant #5 reported kind treatment and no fear of staff members.

Tenant #6, a 97 year old, was admitted 7-26-10 with diagnoses of: Arthritis, HTN, and Anemia. The cognitive assessment dated 2-25-11 indicated Tenant #6 had little or no cognitive impairment. Tenant #6 no longer resided at the program.

Tenant #7, a 92 year old, was admitted 9-2-08 with diagnoses of: Congestive Heart Failure, Depression and Diabetes. The program's cognitive assessment dated 11-30-11 indicated Tenant #7 had little or no cognitive impairment. Tenant #7 reported that all staff members were kind and respectful.

Tenant #8, a 72 year old, was admitted 11-18-09 with diagnoses of: Congestive Heart Failure, Hypothyroidism, and Dementia. The cognitive assessment dated 4-20-12 indicated Tenant #8 had little or no cognitive impairment. The monitors attempted to interview Tenant #8 multiple times and were unable to make the contact.

Tenant #9, a 64 year old, was admitted 2-15-12 with diagnoses of: HTN, Diabetes, Chronic Depression, and Chronic Pain. The cognitive assessment dated 2-8-12 indicated Tenant #9 had little or no cognitive impairment. The monitors attempted to interview Tenant #9 multiple times and were unable to make the contact.

Tenant #10, an 85 year old, was admitted 11-8-08 with a diagnosis of Congestive Heart Failure. The cognitive assessment dated 4-2-12 indicated Tenant #10 had little or no cognitive impairment. Tenant #10 reported kind treatment and no fear of staff members.

Tenant #11, a 90 year old, was admitted 7-22-09 with diagnoses of: Diabetes, Arthritis, and Prostate Cancer. The cognitive assessment dated 3-2-12 indicated Tenant #11 had little or no cognitive impairment. The monitors attempted to interview Tenant #11 multiple times and were unable to make the contact.

The tenants reported occasional incidents when staff members were short tempered and loud. However, they reported general satisfaction with the cares provided by the staff members. While a deviation from the requirement of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged that staff failed to report to the nurse when a tenant fell and told the tenant not to report it.

- Monitoring Observation: The monitors reviewed 11 clinical records and program incident reports for the prior three months and interviewed Staff #1 and #2.

  Tenant #7 reported falling with a staff member present. Tenant #7 stated the staff member said not to report the incident. The clinical record for Tenant #7 did not contain documentation of a fall or incident; however, the Operations Manager reported she had investigated a report from a family member regarding a fall. The Operations Manager stated she was unable to verify a fall and all staff members denied telling any tenant not to report any incidents. The Operations Manager was unable to find documentation of her investigation.

  The clinical record of Tenant #8 contained a Confidential Reportable Event form which documented Tenant #8 sustained a fall on 3-25-12. The home health aide responded to the pendant call and failed to notify the nurse regarding the fall so an assessment could be completed.

  Staff #1 reported knowledge of the program policy to complete an incident report for tenant injuries and falls. She stated that if the nurse was on the premises, she would notify her but otherwise would handle it herself. Staff #2 reported knowledge of the program policy to complete an incident report and stated that she would notify the nurse to assess the tenant for injury before moving the tenant.

  While a deviation from the requirement of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted

During the course of the investigation, the following information was identified.

C. Evaluation

- Monitoring Observation: Tenant #1's evaluation, completed 1-27-12, indicated Tenant #1 began experiencing a change in condition which required staff members to assist with transfers in the evening. Occupational therapy (OT) and physical therapy (PT) services were ordered for Tenant #1 by the physician on 1-27-12. The occupational services were never initiated and the physical therapy discharge dated 2-7-12 indicated the therapist had been providing services to Tenant #1 with the goal of Tenant #1 returning to independent transfers. On 2-7-12 the therapist documented Tenant #1 met that goal. The clinical record lacked evidence that health, functional and cognitive evaluations were completed with the significant change in condition for the improvement in condition when Tenant #1 returned to independent transfers.

  Tenant #4's clinical record included documentation indicating Tenant #4 began experiencing an increase in confusion. During interview, staff members indicated Tenant #4 began wandering more around the program and quit eating meals independently. The nurse completed an evaluation of Tenant #4's health and functional status after identifying the change in condition; however, she did not

complete a cognitive evaluation with this change, citing Tenant #4's inability to answer questions as the reason. The nurse did not complete a GDS, which is a subjective assessment tool that does not require answering questions.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

D. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged that a tenant fell frequently, exceeding the level of care criteria for assisted living.

- Monitoring Observation: The monitors reviewed the clinical records of Tenant #1, #7, #8 and #9 who had sustained falls, finding no concerns. The monitors also interviewed Staff #1 and #2.

  The evaluation for Tenant #9, dated 3-2-12 and 3-15-12, documented Tenant #9 required assistance for transfers and ambulation. The evaluation, completed 4-26-12, documented Tenant #9 was independent with transfers and ambulation. The service plans did not address specifics as to what type of assistance was required.
  The clinical record for Tenant #9 contained evidence of falls as follows:
  1. 2-22-12- Tenant slid out of chair un-witnessed
  2. 2-29-12- Tenant slid out of electric wheelchair un-witnessed
  3. 3-3-12- Tenant slid out of chair un-witnessed
  4. 3-3-12- Tenant fell in kitchen during transfer un-witnessed
  5. 3-4-12- Tenant fell to floor witnessed by a family member
  6. 3-31-12- Tenant fell in bedroom while transferring from chair to bed un-witnessed
  7. 4-3-12- Tenant fell to floor coming out of bathroom un-witnessed
  8. 4-3-12- Tenant fell to the floor by the front door of apartment un-witnessed

  No significant injuries were identified for any of the falls.

  The program initiated physical therapy on 3-2-12 and Tenant #9 was discharged from therapy on 3-26-12. The program completed a managed risk agreement with Tenant #9 on 3-7-12 which indicated if Tenant #9 continued to fall more than one time a week, Tenant #9 would exceed the community's level of care criteria. The program reevaluated and initiated physical therapy again on 4-7-12. There have been no documented falls since 4-3-12.

  Staff #1 and #2, universal workers, reported there were no tenants who exceeded level of care criteria.

The monitors did not identify any tenants who exceeded the level of care criteria for assisted living.

- Regulatory Insufficiency: None noted

E. Tenant Documents

Complaint/Incident Allegation: It was alleged home health aide visit notes were forged with tenants' signatures to indicate that services had been provided when they had not.

- Monitoring Observation: The regulations for assisted living contain no requirements for maintenance of home health aide records

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following information was identified.

F. Service Plans

- Monitoring Observation: Tenant #1's service plan, dated 1-27-12, indicated Tenant #1 was receiving PT and OT services one to two times a week for four weeks. The registered nurse (RN) updated Tenant #1's service plan on 3-27-12 documenting Tenant #1 had no changes. The service plan continued to include the PT and OT services as an intervention. According to the PT discharge note, Tenant #1 met all goals and was discharged from therapy services on 2-12-12. Tenant #1's clinical record lacked documentation that OT services were ever initiated. Both PT and OT services remained as interventions on the current service plan. The Clinical Supervisor concurred that OT services had not been initiated.

  Tenant #2's functional evaluations, completed 2-3-12 and 4-3-12, documented Tenant #2 required assistance with dressing, grooming, and bathing, indicating Tenant #2's spouse assisted Tenant #2 with all three tasks. The same evaluation indicated Tenant #2 would receive a whirlpool bath once weekly provided by staff members. The service plan dated 2-3-12 and 4-3-12 failed to identify that Tenant #2 required assistance with grooming or dressing. The service also indicated the whirlpool was to be given two times a week. During interview, Tenant #2 stated his/her spouse does assist with daily dressing and grooming and staff members assist with a whirlpool only once a week.

  Tenant #3's functional evaluations, completed 1-19-12 and 3-20-12, documented Tenant #3 ambulated with assistance. During interview, Tenant #3 reported he/she ambulated independently in his/her apartment when using a cane. Tenant #3 reported he/she is no longer able to ambulate outside of the apartment due to leg weakness and safety reasons. Tenant #3 reported using a motorized scooter at all times when leaving the apartment. The service plans, dated 1-19-12 and 3-20-12, lacked specific interventions for ambulation.

Tenant #4's clinical record included documentation indicating Tenant #4 began experiencing an increase in confusion on 3-12-12. During interview, staff members indicated Tenant #4 began wandering around the program more and quit eating meals independently. The nurse did not make any changes to Tenant #4's service plan to reflect staff needing to remind, cue and assist Tenant #4 as needed with eating. The nurse also did not make any changes to Tenant #4's service plan to reflect Tenant #4's behavior of wandering and interventions staff members could use to redirect Tenant #4 when wandering. Tenant #4 moved from the program on 3-19-12 with the program documenting Tenant #4 exceeded the assisted living level of care.

Tenant #7's functional evaluation, completed 4-20-12 after a hospitalization for a fractured hip, documented Tenant #7 required assistance with transfers, dressing, grooming, bathing, toileting, ambulation and medication. The service plan dated 4-20-12 lacked specific interventions for assistance with transfers, grooming, toileting or ambulation.

Tenant #8's clinical record included a service plan initially dated 12-17-09. The plan was updated annually as required on11-27-10 and 11-30-11; however, the service plan updates lacked the signature of the tenant.

Tenant #9's functional evaluation, completed 3-2-12, documented Tenant #9 required assistance with transfers, bathing, ambulation and medication. The service plan dated 3-2-12 lacked specific interventions for assistance with transfers or ambulation. Although the service plan also documented Tenant #9 received physical therapy services it was not specific as to frequency or duration of the therapy.

Tenant #10's clinical record included a service plan initially dated 2-10-11. The plan was updated 1-2-12, but lacked the signature of the tenant.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

- Regulatory Insufficiency: All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26 (2))

G. Other

Complaint/Incident Allegation: It was alleged that individual tenant's mail was being thrown away.

- Monitoring Observation: The monitors observed mail delivery from the Post Office directly into each tenant's locked mail box. The tenants maintained the keys to their individual mail boxes. Tenant #2, #5 and #10 reported no concerns with mail being taken from their boxes.

- Regulatory Insufficiency: None noted.