IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 42402-I
42378-C

March 8, 2013

Mr. Stephen King, Administrator
Rose of Ames Assisted Living
1315 Coconino Road
Ames, IA 50014

RE: Final Complaint/Incident Investigation Report, Rose of Ames Assisted Living, Ames, Iowa

Dear Mr. King:

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 Insufficiency, 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:

Stephen King, Administrator
Rose of Ames Assisted Living
1315 Coconino Road
Ames, IA 50014

Complaint/Incident Intake #: 42402-I
42378-C

Date of Complaint/Incident Investigation:

February 18th and 19th, 2013

Monitor(s):

Lori Miner, RN BSN

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:	52
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	53
TOTAL census of Assisted Living Program	53

Program History – The program received a regulatory insufficiency in the area of service plan during the Dec. 19, 2012, Recertification visit.

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

A. Program Reporting to the Department

Complaint/Incident Allegation: The program reported to the department the death of Tenant #1 (42402-I). It was alleged the cause of death may have been suicide (42378-C).

- Monitoring Observation: Tenant #1, a 65 year-old, was admitted on 2-17-09 and had diagnoses of: Emphysema, Chronic Diarrhea, Myalgia, Bipolar Disorder, Esophageal Reflux, Hypothyroidism, Chronic Ischemic Heart Disease, and Diabetes. The cognitive screening tool showed no cognitive impairment. Tenant #1 was hospitalized 11-30-12 for angioedema, an allergic reaction to the medication Lisinopril. Tenant #1 returned to the Program on 12-4-12. Evaluations were completed on 12-4-12. The visit report of the same date indicated Tenant #1 was depressed about his/her health, but neither the visit report nor the evaluations indicated suicidal thoughts. The service plan, updated 12-4-12, did not identify Tenant #1 as a suicidal risk. A visit report dated 12-10-12 indicated Tenant #1 had no anxiety or depression. An incident report dated 12-11-12 indicated Tenant #1, who self-administered medications from a pre-filled planner, had taken the pills from the 12-11-12 morning slot, was occupied in the apartment, then took the pills from the 12-12-12 morning slot. Tenant #1 reported the error to the Program Nurse when Tenant #1 realized the pills had been "doubled up." The physician was notified with no orders received. The Program Nurse discussed with the Home Health Case Manager a plan to obtain a medication machine for Tenant #1. The visit report dated 12-17-12 indicated Tenant #1 had some issues with depression with the holidays, but there was no documentation that indicated Tenant #1 was suicidal.

Staff #1 Certified Nursing Assistant (CNA), #2 CNA, and #3 Home Health Aide (HHA) were interviewed as well at the Program Nurse. All indicated Tenant #1 had no suicidal thoughts.

An incident report dated 12-19-12 at 4:50 p.m. indicated a delivery service delivered a package at the door for Tenant #1. The delivery driver had knocked at the door, but no one answered. At the same time, the dietary department called the nurse's station and stated Tenant #1 signed up for the evening meal, but had not shown up for the meal. A staff member went to the apartment and found Tenant #1 lying in bed on his/her side. Tenant #1 did not respond and had no pulse and 911 was called. Paramedics contacted the medical examiner. According to the death certificate, Tenant #1 died of natural causes.

Tenant #2, a 76 year-old, was admitted on 6-1-08 and had diagnoses of: Spinal Stenosis and Diabetes Mellitus Type II. A visit report dated 12-10-12 indicated Tenant #2 was very tearful, and reported an emotional year. The Home Health Case Manager asked Tenant #2 if he/she wanted to get help, and Tenant #2 replied yes. Tenant #2 was transported to the hospital via ambulance. Tenant #2 was admitted with suicidal ideations. Tenant #2 returned to the Program on 12-24-12 and denied suicidal ideations. The service plan alerted staff members to report to the nurse if Tenant #2 expressed suicidal thoughts. A visit report dated 12-26-12 at approximately 3:30 p.m. indicated Tenant #2 was tearful and depressed, but denied suicidal ideations. According to the communication log, later in the day on 12-26-12, Tenant #2 phoned 911 and reported wanting to take pills because he/she did not want to live anymore. Tenant #2 was transported via ambulance to the hospital. A physician's order dated 1-21-13 indicated Tenant #2 was admitted to a nursing facility and discharged from the Program.

According to the death certificate, Tenant #1 died of natural causes. The Program was not required to report a death due to natural causes. Tenant #2 verbalized suicidal ideations, but did not make attempts at suicide. The Program was not required to report verbalization of suicidal ideations.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged medications were being set up incorrectly (42378-C).

- Monitoring Observation: The Program identified 14 tenants for whom medications were set up in planners. A home health agency provides staffing for health care needs with one nurse identified as the program nurse in the assisted living program. Planners for five tenants (#3, #4, #5, #6, #7) were reviewed. The pills in the planner were counted and compared to the current medication report. The pills in the planner were also compared for size and color to the labeled medication bottles. Planners for the five tenants were filled correctly. According to the Program Nurse, the planners were filled by home health case managers.

Tenant #8, a 90 year-old, was admitted on 3-1-10 and had diagnoses of: Neurogenic Bladder, Hypertension, Extrapyramidal Disease, Osteoporosis, Hypothyroidism, and Depressive Disorder. Tenant #8 had been admitted to the hospital following a fall and urinary tract infection, and returned to the Program after rehabilitation. According to the medication report, Gabapentin was given for analgesia. The planner for Tenant #8 was reviewed. The Program Nurse stated she filled the planner on 2-15-13, a Friday, as Tenant #8 had returned to the Program after hospitalization. The planner was filled for the week. The following was found in the planner on the afternoon of 2-18-13, a Monday:

Morning medications: 12 pills were ordered, nine were in the planner. Missing from the planner was Ex Forge, a new medication; Calcium Carbonate as Tums for indigestion, ordered 10-8-12; and Vitamin B 1, two tablets, a new medication.

Noon medications: Seven pills were ordered, six were in the planner. Missing from the planner was Digestive Enzymes ordered 10-8-12. Fish Oil was ordered as 500 milligrams (mg) daily. A Fish Oil pill was in the noon planner, but the medication bottle was labeled 1000 mg. The Fish Oil was originally ordered 10-8-10 and changed 10-8-12.

Bedtime medications: An extra pill was in the bedtime slot of the planner. Two Gabapentin were in the planner. The medication report indicated 300 mg of Gabapentin was to be given three times a day, which indicated one Gabapentin should have been in the planner at bedtime. The medication bottle for the Gabapentin indicated an additional pill was to be given at bedtime. The planner was not filled according to the order for Gabapentin which was ordered 10-8-12.

Two new medications were not in the planner for the week. One medication was missing from the morning slot, one was missing from the noon slot, and the noon slot also contained the incorrect dosage of Fish Oil which was ordered 10-8-12. The bedtime slot contained an extra pill of Gabapentin. The planner was not filled according to the orders.

- Regulatory Insufficiency: When medications are administered traditionally by the program: (a) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

C. Staffing

Complaint/Incident Allegation: It was alleged the Program was understaffed. It was alleged a staff member was unable to lift due to an injury and could not respond in an emergency. It was alleged a staff member was not doing her job. It was alleged a staff member was sleeping during the day shift. It was alleged there was a shortage of nurses. (42378-C)

- Monitoring Observation: The staffing plan and staff schedules for December 2012 and January – February 2013 were reviewed. The schedule was completed and

followed the staffing plan. Staff #1 who identified herself as a Certified Nurse's Assistant and scheduler, identified no problems with the schedule.

According to RN #1 the Program had a staff member on workman's compensation with restrictions, but the restrictions were lifted in November 2012. Staff member's #1, #2, and #3 were interviewed. Staff #1 and #2 indicated there were no staff members that were not able to perform their job duties. Staff #3 indicated she could not lift more than 30 pounds but was able to carry a full work load. Staff #1, #2, and #3 indicated all cares were provided and there was enough staff to meet the needs of the tenants. Staff #1, #3, and the Program Nurse indicated staff members called another staff member or the on-call nurse for assistance if a staff member was unable to get a tenant up after a fall.

No staff members were observed to be sleeping during the onsite visit. The Program Nurse reported no concerns with staff members sleeping while at work.

Assisted living regulations require a nurse be available. The Program Nurse was onsite both days during the onsite visit. Staff interviews indicated an on-call nurse was available.

A group interview was completed with three tenants. Private interviews were conducted with four additional tenants. For those receiving personal services, all indicated services were provided and there were no concerns with cares. Staff members were reported to respond promptly to requests for assistance. Three tenants identified Staff #3 as not completing housekeeping services and coming into the apartment to sit and not do the cleaning. Two of the three indicated they had verbalized concerns and now had a new housekeeper. The Program provided signed documentation during the month of February 2013 from four tenants (#5, #9, #10, #11) which indicated Staff #3 performed cleaning services satisfactorily.

- Regulatory Insufficiency: None noted.