IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 45944-I

November 25, 2013

Mr. Ronald Osby, Administrator
Arbor Heights at University
233 University Avenue
Des Moines, IA 50314

RE: Final Complaint/Incident Investigation Report – Arbor Heights at University, Des Moines, IA

Dear Mr. Osby:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of November 20, 2013, 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 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:

Ronald Osby, Administrator
Arbor Heights at University
233 University Ave.
Des Moines, Iowa 50314

Complaint/Incident Intake #:

45944-I

Date of Complaint/Incident Investigation:

November 20, 2013

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:	17
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	18

Program History – The program received a regulatory insufficiency in the area of Service Plan during the November 2011 Recertification on-site.

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

Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant attempted to fuse together two oxygen tubing pieces using a flame from a cigarette lighter. The tenant did not shut off the oxygen which ignited causing burns to the tenant's hands and smoke in the building.

- Monitoring Observation: Tenant #1, a 69 year old, was admitted to the program on 8-30-13 and currently resided at the program. Tenant #1 had diagnoses of Anxiety, Depression, Diabetes, Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Chronic Pain. Tenant #1 answered all questions correctly on the program's cognitive evaluation tool completed on 8-30-13 and all but one question correctly on the cognitive evaluation tool completed on 10-25-13, indicating no cognitive impairment. Tenant #1 was independent with all activities of daily living. Tenant #1 had a past history of narcotic medication abuse. Due to the history of narcotic medication abuse, Tenant #1's physician refused to prescribe medications to Tenant #1 unless he/she was living in an assisted living type setting. The program administered medications to Tenant #1. According to the Medication Administration Sheets Tenant #1 used oxygen 2 to 3 liters per nasal cannula at night only.

  According to the Incident Report, dated 10-20-13 and Nurse Notes, dated 10-20-13, the program's fire alarms sounded at approximately 2:30 p.m. The program's alarm system indicated the fire was located in Tenant #1's apartment. Staff members responded to the alarm, going to Tenant #1's apartment. The staff members observed smoke in the apartment and a blackened oxygen tube lying on Tenant #1's bed. Tenant #1 had burns on his/her hands. The oxygen tubing was still attached to the oxygen concentrator and the oxygen concentrator was still plugged into the wall but the flow of oxygen had already been shut off. The staff members did not find an actual fire in the apartment. Tenant #1 told staff members he/she had been attempting

to fuse two oxygen tubing pieces together to increase the length of the tubing by heating up the plastic tubing with a cigarette lighter. Tenant #1 reported forgetting to shut the oxygen off at the concentrator prior to using the lighter.

During interview, Tenant #1 reported he/she needed a longer oxygen tubing so, when wearing the oxygen at night as ordered by the physician, Tenant #1 could reach the bathroom in his/her apartment. Tenant #1 reported asking an assisted living staff member for a longer tubing a few days before the incident on 10-20-13. Tenant #1 reported the staff member told him/her that the program did not have any oxygen tubing. Tenant #1 later attempted to "warm up" the oxygen tubing with a cigarette lighter in an attempt to remold the plastic ends to join without a connector. Tenant #1 reported forgetting to turn off the oxygen prior to using the cigarette lighter, causing the oxygen to burn. A flame reportedly shot out the end of the oxygen tubing that was attached to the oxygen concentrator, burning Tenant #1's hands. Tenant #1 indicated quickly shutting off the oxygen flow at the concentrator which stopped the flame. Tenant #1 concurred the room was filled with smoke and the program's fire alarm did sound. Tenant #1 reported he/she was transported to the emergency room via ambulance and later returned to the program. (Tenant #1 reported using oxygen for "a couple of years.")

During interview, Staff #2, certified medication aide (CMA), reported Tenant #1 did ask her for a longer oxygen tube a few days before the incident. Staff #2 reported she told Tenant #1 that the assisted living program did not keep oxygen tubing on-site. Staff #2 reported telling Tenant #1 he/she would need to contact the oxygen vendor to get the oxygen tubing replaced. Tenant #1 reportedly did not request assistance with contacting the oxygen vendor.

During interview, the program Administrator reported assisted living tenants enter into individual contracts for oxygen provision with vendors who provide such service. The assisted living does not store, provide or sell oxygen and oxygen supplies.

According to hospital discharge papers, Tenant #1 received second degree burns to multiple fingers on the left hand and one finger on the right hand. Tenant #1 was evaluated psychologically while hospitalized. The psychological evaluation determined Tenant #1 to be cognitively intact and competent. The evaluation indicated Tenant #1 had no suicidal ideations and determined the incident involving the oxygen tubing was accidental.

Following Tenant #1's psychological evaluation, the program allowed Tenant #1 to return to the program on 10-25-13.

During interview, Tenant #1 reported the program required Tenant #1 to leave all matches and cigarette lighters with program staff members. Tenant #1 was able to have both items to take off premises but was required to return the items back to staff members when coming back into the program. Tenant #1 indicated he/she had been complying with this requirement since return.

The program gave Tenant #1 notice of 30 day involuntary discharge citing behaviors which were of danger to self or others as the reason for the discharge. Tenant #1 continued to remain at the program at the time of the on-site visit but was actively

searching for another place to live. Tenant #1 was required to find another assisted living to move into as his/her physician required medication administration by caregivers due to Tenant #1's past history of narcotic abuse. Tenant #1 had not yet found an assisted living program to accept him/her.

Tenant #1 received second degree burns secondary to his/her actions on 10-20-13 and placed other tenants residing at the program at risk for serious injury. The program gave Tenant #1 30 days to vacate from the program. The program responded effectively to the fire and tenant injury on 10-20-13, required Tenant #1 to have a psychological evaluation before returning to the program and required Tenant #1 to surrender all matches and lighters to staff members and use such items only off program premises after Tenant #1 returned to the program until Tenant #1 could move to another housing arrangement.

- Regulatory Insufficiency: None noted.