IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47025-I
47020-C

March 26, 2014

Ms. Nwanneke Eke, Administrator
Rose of Des Moines Assisted Living
1330 19th Street
Des Moines, IA 50314

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

Dear Ms. Eke:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of February 25 & March 4, 15, 25, 2014, 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:

Nwanneke Eke, Administrator
The Rose of Des Moines Assisted Living
1330 19th Street
Des Moines, IA 50314

Complaint/Incident Intake #: 47025-I
47020-C

Date of Complaint/Incident Investigation:

February 25 and March 4, 15, 25, 2014

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:	0
Total Population of Program at time of on-site	52
TOTAL census of Assisted Living Program	52

Program History – The program received a regulatory insufficiency in the area of Record Checks during the August 28, 2013 Recertification on-site. During the Complaint Investigation (45645-C, 45647-C), of October 22 and 23, 2013, the program received regulatory insufficiencies in the areas of Evaluation and Service Pan.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged a tenant was subjected to an unwanted sexual encounter (47020-C). The program reported a tenant had a romantic encounter. The encounter was consensual until one of the tenants went too far. (47025-I).

- Monitoring Observation: Tenant #1, a 61 year-old, was admitted on 4-25-13 and had diagnoses of: Arthritis, Neuropathy, Depression, Spinal Fusion, Hypertension, and Pulmonary Hypertension. The current service plan dated 7-8-13 indicated Tenant #1 did not require assistance with activities of daily living and administered medications independently. The Mini-Mental Assessment completed on 11-4-13 indicated Tenant #1 had no cognitive impairment.

  The registered nurse (RN), the Administrator, Staff #1, #2, and #3 were all interviewed. None were aware Tenant #1 had a relationship with any other tenant.

  Tenant #2, a 71 year-old, was admitted on 3-14-13 and had diagnoses of: Diabetes, Hypertension, Arthritis, and Depression. Evaluations of function, cognition, and health and the service plan dated 10-18-13 indicated Tenant #2 did not require assistance with activities of daily living and administered medications independently. The Mini-Mental Assessment completed on 10-18-13 indicated Tenant #2 had no cognitive impairment.

  In August of 2013, Tenant #2 was given a written warning for demonstrating offensive behavior perceived as harassment. Staff #2 was identified as the object of

the behavior. Staff #2 stated Tenant #2 repeatedly asked her to clean the apartment despite the fact the program provided a cleaning service. Tenant #2 also looked at Staff #2 strangely, which Staff #2 perceived as sexual in nature. The RN also indicated a health aide had reported to her that the health aide had been asked by Tenant #2 if the health aide had ever been with a black person.

The Administrator, RN, and Staff #2 all reported Tenant #2 stopped the behavior after the letter was given.

On 1-27-14 during the evening, Staff #4 documented she had a conversation with Tenant #1. During the course of the conversation, Tenant #1 reported Tenant #2 had said "hi honey" which made Tenant #1 feel good. Tenant #1 reported to Staff #4 that on 1-25-14 Tenant #1 was in the hallway and heard noise from a TV. Upon investigating the noise, Tenant #1 found Tenant #2's apartment door to be open. Tenant #1 reported saying "hi honey" to Tenant #2. Tenant #2 motioned for Tenant #1 to enter the apartment. Tenant #1 entered. After talking, Tenant #2 asked for a hug to which Tenant #1 replied it would be "ok." Tenant #2 indicated the need to shower, and then asked Tenant #1 to return later. Around 7:00 p.m., Tenant #2 called Tenant #1 to come back to Tenant #2's apartment. Tenant #1 knocked on the door, entered, and sat on the couch. Tenant #2 sat down next to Tenant #1. Tenant #2 made advances which Tenant #1 initially accepted. During the advances, Tenant #1 stated Tenant #2 was told the advances were no longer wanted, but Tenant #2 persisted. After some time passed, Tenant #2 asked Tenant #1 to stay. Tenant #1 refused to stay and left the apartment. The next day, Tenant #1 saw Tenant #2 in a common area. Tenant #1 reported Tenant #2 looked upset. Tenant #1 reported calling Tenant #2 later and asked Tenant #2 if Tenant #1 had done something wrong. Tenant indicated embarrassment and had not reported the incident earlier.

Staff #4 notified the RN on 1-27-14 of the incident. The RN notified the Administrator of the incident on 1-28-14. On 1-28-14, Tenant #1's service plan was updated with a safety plan.

On 1-29-14 Tenant #1 was seen by the personal physician, and referred to the hospital for further evaluation related to the incident. Tenant #1 indicated to the RN the police department had been notified, and Tenant #1 felt tricked into the examination and notification of the police. Tenant #1 did not want to press charges, but was told the decision to press charges was out of Tenant #1's hands.

The program reported the incident to the Department on 1-30-14. The program completed an investigation including an interview of Tenant #1. Evaluations of function, cognition, and health were completed for Tenant #1 on 1-31-14.

The program attempted to interview Tenant #2, who refused to answer questions. Because Tenant #2 had been given a written warning in August 2013 and did not refute the accounting of the incident as described by Tenant #1, Tenant #2 was issued a 30-day notice of discharge on 1-31-14. Tenant #2 was to vacate the apartment by 2-28-14. The Administrator and Executive Director reported Tenant #2 did not contest the discharge notice.

On 2-4-14, another tenant, Tenant #3, went to the Administrator and indicated knowledge of the incident between Tenant #1 and Tenant #2. Tenant #3 reported a few weeks earlier Tenant #1 had approached Tenant #3 seeking a relationship. Tenant #3 declined the offer.

An interview was conducted with Tenant #1 who reported feeling safe at the program and indicated the safety plan was meeting needs. Tenant #1 reported there had been no contact with Tenant #2.

According to Chapter 231C of the Iowa Code, assisted living programs promote a social model and focus on independence. Tenant #2 had previously made verbal statements in August of 2013 that were perceived as harassment. The verbal statements stopped after the program issued a written warning. Tenant #1 and Tenant #2 were determined to have no cognitive impairment, and initially engaged in a consensual relationship within the confines of Tenant #2's rented apartment. Tenant #1 later declined the advances, which according to Tenant #1, Tenant #2 ignored. Tenant #1 notified the program days after the incident occurred. Tenant #1 was seen by a personal physician as well as hospital staff who performed an examination related to the incident. The police department and the Department were notified. The program evaluated Tenant #1 and updated the service plan to include a safety plan, with which Tenant #1 was satisfied. Tenant #2 was issued a 30-day notice of discharge.

- Regulatory Insufficiency: None noted.