IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47827-I

June 9, 2014

Ms. Felicia Owens, Administrator
Rose of East Des Moines
1331 Idaho Street
Des Moines, IA 50327

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

Dear Ms. Owens:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of June 2, 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:

Felicia Owens, Administrator
The Rose of East Des Moines
1331 Idaho Street
Des Moines, IA 50327

Complaint/Incident Intake #: 47827-I

Date of Complaint/Incident Investigation:

June 2, 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:	62
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	64
TOTAL census of Assisted Living Program	64

Program History – The program received regulatory insufficiencies in the areas of Evaluation and Service Plan during the recertification visit of August 20, 2012. During the Complaint Investigation of August 26, 2013, the program received a regulatory insufficiency in the Area of Structural Requirements.

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

A. Service Plans

Complaint/Incident Allegation: The program reported a tenant death occurred on 4-1-14.

- Monitoring Observation: Tenant #1, a 68 year-old, was admitted on 1-31-14 and had diagnoses of: Arthritis, Bipolar Disorder, Chronic Pain, and Hypertension.

  The program had instituted a door flag system on 4-1-14. According to the policy, and as described by the Registered Nurse #1(RN), late in the evening a small flag which was attached to each apartment door was raised. After a tenant opened the door the next day, the flag would fall. The fallen flag would indicate the tenant had been up and active enough to open the door. Per the policy, if the flag was still up, staff members were to knock on the door, and if no answer, use a key to open the apartment door and visualize the tenant.

  The program had instituted the policy on 4-1-14. At about 4:30 p.m. RN #1 recalled the new policy had been put in place. RN #1 toured the floors and noted that Tenant #1's flag was still up. RN #1 reported she knocked on the door and got no response. RN #1 stated she did not have the keys to open the apartment door and asked the Licensed Practical Nurse (LPN) to unlock Tenant #1's apartment door.

  The LPN reported between 4:00 and 5:00 p.m. on the day of 4-1-14, RN #1 had asked the LPN to check on Tenant #1 because the LPN had keys. The LPN reported she went to the apartment, did not knock as RN #1 indicated she had already done so with no response. The LPN used a key to unlock the door. Upon opening the door, the

LPN observed the bathroom door to be open and the LPN was able to visualize Tenant #1. The LPN described Tenant #1 as unclothed, standing at the sink bent at the waist with head and arms on the bathroom counter area. The LPN continued to describe Tenant #1 as mottled, cold, and in rigor. A toothbrush was in the mouth. The LPN called for RN #1. RN #1 reported the same observations of Tenant #1. The LPN and RN #1 stated Cardiopulmonary Resuscitation (CPR) was not started as Tenant #1 was obviously deceased and the CPR policy indicated CPR was not indicated when a tenant was obviously deceased.

According to the LPN, the paramedics were called and the paramedics contacted the medical examiner. According to documentation by the CEO of the home health agency, the medical examiner observed a bump on Tenant #1's head which appeared to indicate a recent fall. RN #1 reported having no knowledge of a fall prior to the observation of the medical examiner.

According to documentation completed by the CEO, the CEO had contacted the family member on 4-1-14 to notify the family of Tenant #1's death. The CEO asked about a recent fall. The family member reported being with Tenant #1 the day before the death and had observed a bump on Tenant #1's head. The family member reported neither Tenant #1 nor the family had reported the injury to anyone. Progress notes dated 3-26-14 documented RN #1 had been to Tenant #1's apartment and no problems were identified with Tenant #1.

According to the Executive Director, she learned on 4-2-14 that Tenant #1 may have sustained a fall. The death was reported to the Department within 24 hours of the Executive Director learning of the possible fall.

According to the service plan dated 1-31-14, Tenant #1 was independent with bathing, dressing, grooming, and eating, and ambulated independently without assistive devices. A family member set up medications in a planner for Tenant #1 to take independently. The family provided housekeeping and laundry services for Tenant #1. Tenant #1 received no services from the program.

RN #2 was interviewed and stated she completed the pre-admission evaluation of Tenant #1. RN #2 reported Tenant #1 had previously resided in a nursing home and was looking for more social activity. RN #2 reported she let the activity director know of Tenant #1's desire to participate in activities. RN #2 reported Tenant #1 had damage to the gums of the mouth following a previous dental visit and sometimes Tenant #2 did not come to meals because of the gum problem. RN #2 reported Tenant #1opted to receive boxed meals provided by the program.

On 2-17-14, RN #2 completed evaluations within 30 days of admission. RN #2 reported Tenant #2 was happier with the independence and there were no concerns identified.

A tour was taken of Tenant #1's former apartment which was now empty. RN #1 accompanied the surveyor on the tour. The apartment was noted to be warm. The heating system was off, the air conditioning unit was off and the windows were closed. On the day of the visit, the outside air was very warm and muggy. RN #1 reported and the surveyor observed an individual heating control in the apartment.

The air conditioner was also able to be controlled by the tenant. According to RN #1 the air conditioning was available year round. Windows were also able to be opened.

RN #3 stated she had met with Tenant #1 on the day of admission and had oriented Tenant #1 to the temperature controls and Tenant #1 verbalized understanding.

Interviews were conducted with RN #1, RN #2, RN #3, the LPN, and Staff #1. All reported seeing Tenant #1 and did not identify any concerns with Tenant #1. All reported Tenant #1 to be pleasant and no concern was identified with Tenant #1's mental or physical state. All reported they had been to Tenant #1's apartment and there were no concerns about the temperature of Tenant #1's apartment. No one was aware of any maintenance needs in Tenant #1's apartment. It was reported Tenant #1's apartment was neat and clean.

A copy of the Medical Examiner's report was obtained. Tenant #1 died of natural causes. There was no evidence of intracranial pathology.

Tenant #1 resided at the program and was independent with activities of daily living and received no services from the program. Per Tenant #1's request meals were boxed due to a long-standing dental condition. Five staff members interviewed identified no concerns mentally or physically with Tenant #1. Tenant #1 may have fallen; the injury was not reported to the program. Tenant #1 died of natural causes.

- Regulatory Insufficiency: None noted.