IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 48591-I
48603-C
48500-C

July 11, 2014

Ms. Karen Beck, RN Director
Prairie Hills Assisted Living
5815 SE 27th Street
Des Moines, IA 50320

RE: Final Complaint/Incident Investigation Report – Prairie Hills Assisted Living, Des Moines, IA

Dear Ms. Beck:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 7 & 8, 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:

Karen Beck RN, Director
Prairie Hills Assisted Living
5815 SE 27th Street
Des Moines, IA 50320

Complaint/Incident Intake #: 48591-I
48603-C
48500-C

Date of Complaint/Incident Investigation:

July 7th and 8th, 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:	32
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	43
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	2
TOTAL census of Assisted Living Program	45

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

A. Structural Requirements

Complaint/Incident Allegation: It was alleged water was leaking into apartments from nearby mechanical rooms (48603-C).

- Monitoring Observation: Through staff interviews (Licensed Practical Nurse (LPN) #2, Office Manager, Maintenance) it was determined there had been three areas in the program where carpeting had gotten wet from water leaking from a nearby mechanical room. The areas identified were a mechanical room near the kitchen affecting an occupied apartment, a mechanical room near the employee break room affecting the break room, and a mechanical room in the dementia unit affecting an unoccupied apartment. According to Maintenance, the air conditioning system had frozen and a repairman was called to fix the problem. Maintenance reported on one occasion the repairman thought the problem was fixed; however, the problem quickly returned. The repairman was again called and the problem was fixed.

  The carpeting and drywall was checked in the apartment near the kitchen, the apartment in the dementia unit, and the employee break room. The apartment near the kitchen was accessed after receiving permission from the tenants residing in the apartment. The wall and carpeting next to the associated mechanical room was found to be dry. Tenants #1 and #2 reported having dry carpet and no further issues with water in the apartment.

The drywall and carpeting was dry in the employee break room, the occupied apartment near the kitchen, and the unoccupied apartment in the dementia unit. The three mechanical areas were observed and there was no water present on the floor in the mechanical rooms.

Maintenance provided documentation of monthly inspections of apartments which included mold inspections.

Three areas were identified as having had water leak from nearby mechanical rooms. The mechanical rooms and adjacent areas were found to be dry. An identified problem had been fixed.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member yelled and swore in front of tenants. It was alleged housekeeping was not being provided (48603-C). The program reported it received an allegation that staff members yelled at tenants and were rude. (48591-I)

- Monitoring Observation: Two tenants reported a Maintenance yelled at a visitor. Neither tenant reported any swearing occurred. Staff #1 and #2 were identified by the tenants as present in the building at the time of the incident.

  Staff #1 was interviewed and stated Maintenance was called to fix a problem. Staff #1 stated a visitor had entered a sprinkler room, a restricted area, and found water on the floor. Maintenance came into the building and Staff #1 observed Maintenance enter an apartment. Staff #1 stated she was outside the door and did not hear any yelling or swearing.

  Staff #2 was interviewed and stated a visitor went into the sprinkler room and Maintenance told the visitor the sprinkler room was restricted, and only employees were to enter. Staff #2 reported continuing with work duties and walked away. Staff #2 reported Maintenance was not using a loud voice.

  Maintenance was interviewed and stated he was called in because of water in an apartment. The maintenance log documented the date of the occurrence as 6-1-14. Maintenance reported a visitor had gone into the sprinkler room which was clearly marked as an employee-only area. Maintenance voiced concern that something may have been touched that would have affected all the tenants.

  Maintenance reported asking the visitor to step outside the apartment so as not to involve or upset the tenants. Maintenance reported generally having a loud voice, but stated there was no use of inappropriate language. Maintenance reported telling the visitor it was not appropriate to be in the sprinkler room. Maintenance stated he proceeded to clean up the water in the apartment and sprinkler room. A service

company was contacted to fix the problem that resulted in the water. Maintenance reported there has been no further issue of water from the sprinkler room.

The program reported to the department that a complaint was received which alleged the Registered Nurse (RN) yelled at a tenant. It was also alleged Staff #3 was rude to a tenant in the Fall of 2013.

Because the allegations involved the RN, an administrator, the program utilized a third party to conduct an internal investigation. The investigation resulted in no disciplinary action as a witness did not hear the RN yelling at a tenant. The investigation into the reported incident involving Staff #3, which occurred months earlier was not substantiated, but the Staff #3 received further training on tenant rights.

The RN was interviewed. The RN stated on the morning of 5-7-14, as the RN was walking through the dining room making usual visits with tenants during breakfast, the RN observed Tenant #3 seemed upset. The RN stated she sat down next to Tenant #3 and talked in a normal tone of voice, trying to educate Tenant #3 on concerns voiced. The RN stated the Dietary Manager was witness to the interaction.

The Dietary Manager was interviewed. She stated she observed the RN on the morning of 5-7-14. The Dietary Manager reported she was in the dining room serving breakfast. The Dietary Manager reported she heard the RN say "that's not true" and observed the RN pull out the chair next to Tenant #3 and sit down. The Dietary Manager reported at no time during the conversation did the RN raise her voice or become loud, and was sitting next to Tenant #3, who was described as somewhat hard of hearing, but not so close as to be "in the face." The Dietary Manager reported she had not heard any staff member be loud, rude, or swear at tenants.

Staff #2 was interviewed and stated he was not aware of any situation where staff members were rude, yelling, or swearing.

Staff #4 was interviewed. Staff #4 stated she worked with Tenant #3. Tenant #3 did not verbalize fear or the feeling of being threatened. Tenant #3 did not verbalize to Staff #4 that any staff member had been rude. Staff #4 stated no tenants have complained of staff members being rude or threatening.

Staff #5 was interviewed and stated she was not aware of any staff member being rude or threatening to any tenant.

Staff #6 stated she has never heard any yelling and has not observed any staff member yelling at tenants.

A meeting was held with 18 tenants and one family member. It was reported the best thing about the program was the staff. Staff was reported to provide good care and treated the tenants well. Staff members were reported to be respectful. The tenants were asked if they had been subjected to yelling or swearing and they replied they had not. When asked if they had observed any other tenant yelled at or treated disrespectfully, the tenants replied they had not.

The tenants also reported housekeeping was completed to their satisfaction with no reports of any concerns. It was also reported that tenants were able to control the temperature of the apartments by use of the thermostat. Tenants also reported that temperatures in the common areas were comfortable. During the onsite visit, the room temperature of the private dining room was warm. Upon request, the thermostat was adjusted and the room began to cool.

During the tenant meeting, the tenants indicated the program utilized two systems for staff notification of the need for assistance. Tenants were to use a call pendant in an emergency situation, where immediate assistance was needed. Tenants reported staff responded in less than five minutes when call pendants were used. Tenants reported if a staff member was needed for something non-emergent such as assistance with socks or an item out of reach, the tenant was to use the telephone to call the staff member assigned to their hallway. Tenants reported they knew what number to call for their hallway. Tenants reported response to telephone calls for non-emergent assistance was less than 15 minutes.

There was not a preponderance of evidence to support a violation of tenant rights.

- Regulatory Insufficiency: None noted.

C. Evaluation

Complaint/Incident Allegation: It was alleged a tenant was not evaluated in a timely manner (48500-C). The program reported an allegation that a tenant was not evaluated in a timely manner (48591-I).

- Monitoring Observation: The program reported it received an allegation that Tenant #3 was not evaluated in a timely manner by LPN #1.

  Tenant #3, a 90 year-old, was admitted on 3-29-14 and had diagnoses of: Hypertension, Chronic Kidney Disease, Anxiety Disorder, Chronic Pain, and Depression.

  Nurse notes dated 5-7-14 and timed 1:00 p.m. for Tenant #3 documented LPN #1 received a call from a family member to report Tenant #3 had slurred speech and was not making sense. The family member requested LPN #1 to check on Tenant #3. Documentation from an internal investigation indicated LPN #1 had been working on the computer when the call came in. LPN #1 took a minute to finish the entry, then went to Tenant #3's apartment. LPN #1 found Tenant #3 sleeping in the electric scooter. LPN #1 proceeded to check cognitive ability by asking questions related to day and time. LPN #1 observed Tenant #3 did not have slurred speech, no facial drooping, and had equal grips. The family member had indicated during the phone call that Tenant #3 was upset. LPN #1 proceeded to talk to Tenant #3. LPN #1 documented in the nurse notes that Tenant #3 reported not wanting or willing to do anything for self. Tenant #3 reported wanting to go to sleep and die. LPN #1 was in the process of assisting Tenant #3 with a transfer from the scooter to the chair when

family members arrived. The family requested the physician be contacted for admission to the hospital because the family reported Tenant #3 had slurred speech. Nurse notes documented LPN #1 contacted the physician. According to the nurse notes, the physician would not directly admit Tenant #3 to the hospital but Tenant #3 could go to the emergency room. According to the nurse notes, the family requested Tenant #3 be sent to the hospital and an ambulance was called at 1:55 p.m.

LPN #2 reported she was working on 5-7-14, but was unaware of the situation with Tenant #3 until LPN #1 was collecting materials to send to the hospital with Tenant #3. LPN #2 stated she then went to Tenant #3's apartment with LPN #1. Tenant #3 was sitting in the chair with eyes closed. LPN #2 reported Tenant #3 would not stand and the ambulance personnel had to lift Tenant #3 onto the cart. LPN #2 reported at that time Tenant #3 stated "I'm cold." LPN #2 reported those words were clear and the speech was not slurred. LPN #2 thought something was wrong with Tenant #3 when Tenant #3 would not stand. LPN #1 reported Tenant #3's condition had changed since she originally entered the apartment at around 1:00 p.m. Tenant #3 was transported to the hospital via ambulance and did not return to the program.

The program completed an internal investigation using a third party. It was determined LPN #1's evaluation did not include vital signs. LPN #1 was counseled on taking vital signs with an evaluation.

Tenant #4, a 98 year-old, was admitted on 5-6-11 and had diagnoses of: Hypertension, Diabetes, and Parkinson's Disease. Tenant #4 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant #4 was independent with ambulation and transfers. Nurse notes dated 5-3-14 documented Tenant #4 fell in the apartment and had a deformity to the femur. Tenant #4 was transferred to the hospital via ambulance and did not return to the program.

Tenant #5, a 92 year-old, was admitted on 4-8-14 and had diagnoses of: Chronic Obstructive Airway Disease, Congestive Heart Failure, Chronic Renal Failure, Diabetes, and Hypertension. Nurse notes dated 5-7-14 documented Tenant #5 was short of breath and included evaluations of vital signs, lung sounds, and oximetry reading. Tenant #5 was taken to the hospital and did not return to the program. Notes of 5-8-14 documented Tenant #5 was admitted to a hospice house.

Clinical records were reviewed for three tenants. There was no documentation to suggest evaluations were not completed in a timely manner.

- Regulatory Insufficiency: None noted.