IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 48747-C, 49067-C
49209-C, 49334-C

August 11, 2014

Mr. Craig Bell, Administrator
Rose of Waterloo
421 Oak Avenue
Waterloo, IA 50703

RE: Final Complaint/Incident Investigation Report – Rose of Waterloo, Waterloo, IA

Dear Mr. Bell:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 30, 31 and August 4, 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

Complaint/Incident Intake #: 48747-C, 49067-C
49209-C, 49334-C

Craig Bell, Administrator
Rose of Waterloo
421 Oak Avenue
Waterloo, IA 50703

Date of Complaint/Incident Investigation:

July 30, 31 & August 4, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	60
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	62
TOTAL census of Assisted Living Program	62

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

A. Tenant Rights

Complaint/Incident Allegation #49067-C: It was alleged medications were not administered as requested resulting in a tenant being hospitalized and the tenant's eventual death.

- Monitoring Observation: Three tenant files were reviewed.

  According to a statement by the Director of Nursing (DON), "we do not administer any medications to our clients. The nurse sets up meds either using a weekly med file or an MD2 machine. We give verbal reminders to clients who need them; otherwise the residents themselves are independent with taking care of their own medications."

  Tenant #1, an 83 year old, was admitted on 1-24-13 and diagnoses included: Old Cardio Vascular Accident with Seizures and Osteoarthritis. According to Tenant #1's Service Plan dated 9-12-13, medication set up was completed weekly by Tenant #1's family. According to a Coordination of Care Note dated 9-12-13, Tenant #1's family was hospitalized and unable to provide services. Arrangements were made for a home health referral for bathing and homemaking. Family would continue to set up medications and dressing changes to right foot.

  According to a Daily Client Communication Sheet dated 9-12-13 at 4:00 p.m., Tenant #1 needed medication reminders. Care Call Notes were provided for Tenant #1 that indicated medication reminders were completed. Care Calls Notes dated 9-22-13, 9-25-13, 9-26-13, 9-27-13, 9-28-13 and 9-29-13 indicated morning medication reminders and 9-26-13, 9-27-13, 9-28-13, 9-29-13 and 9-30-13 indicated evening medication reminders. A Care Call Note dated 10-1-14 at 9:15 a.m. indicated morning medication reminder for a total of 11 Care Calls in September 2013 and 1 Care Call in October 2013.

According to Coordination of Care Notes dated 10-1-14 Tenant #1 was found in the back of the building in the rocks. Tenant #1 stated he/she was walking with a walker and the walker went off the sidewalk. With the assistance of a nurse and the Administrator, Tenant #1 was assisted up into a seated walker. Tenant #1 declined any pain before moving and had an abrasion on the right hand cleaned with soap and water and bandage applied. Tenant #1 was assisted to lie down in bed and stated he/she would lie down for 10 to 20 minutes and then get up. Tenant #1 declined any shortness of breath or chest pain. According to the Coordination of Care Notes dated 10-2-13, Tenant #1 was admitted to the hospital. On 10-3-13 Tenant #1 was admitted to the Intensive Care Unit. On 10-24-13 Tenant #1 was admitted to a nursing home and rehab center. According to the Coordination of Care Notes dated 11-16-13 Tenant #1 passed away.

Review of Tenant #1's file and a statement from the DON indicated medication reminders were provided and documented. Tenant #1 did not reside at the Program after 10-1-13.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #49067-C: It was alleged the Dietary Manager denied a tenant food, refused to serve a tenant and did not leave trays when the tenant missed meals resulting in the tenant being hospitalized and the tenant's eventual death.

- Monitoring Observation: A community meeting was held with 22 tenants. The tenants stated they had never been refused a meal or refused to be served, nor had then observed any present or past tenant being refused to be served. They were never denied food trays. If a tenant was sick and needed a tray delivered physician approval was needed to receive the tray.

  The Program recorded lunch and supper meals for each tenant, indicating if the tenant was present, absent, in the hospital, received a box meal or did not give a 2 day notice. Reports for lunch and supper meals were reviewed from June 2013 through October 2013.

  Meal reports for June 2013 indicated Tenant #1 was in the hospital for lunch and supper the entire month. July 2013 reports indicated Tenant #1 was hospitalized from July 1 through 11, 2013. From July 12, 2013 through October 1, 2013, the meal reports indicated Tenant #1 was either served, hospitalized or did not give two days' notice.

  Staff #2 was interviewed and stated she was not aware of any present or past tenant being refused meals or being refused to eat in the dining room. She stated there was always food.

  The DON was interviewed and stated she was not aware of any present or past tenant having been refused their meals or being refused to be allowed to eat in the dining room. She was not aware of any tenants not being provided a food tray.

The Dietary Supervisor was interviewed and stated she would refuse to serve tenants if they were not written down to eat, since meals must be ordered two days in advance. She stated box meals were filled and left in the community room refrigerator for tenants to get at a later time. She stated she never refused to serve Tenant #1.

The Administrator was interviewed and stated he was not aware of any present or past tenants being refused their meals or not being allowed to eat in the dining room. He stated a physician statement was needed if a tenant was not coming to the dining room routinely and needed a tray delivered.

Review of meal records, interviews with tenants at a community meeting, Staff #2, the DON, Dietary Manager and Administrator indicated tenants were not denied their meals or restricted from eating in the dining room. When requested, box meals were left for tenants and trays were delivered to tenants' rooms with a physician statement.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation #49334-C: It was alleged a tenant requested two hour checks post hospitalization and the checks were not completed; the tenant was left in a wet protective undergarment and the protective undergarments were not changed as requested.

- Monitoring Observation: The Program provided a list of tenants who had been discharged from the hospital from March 2014 through August 2014. None of the tenants discharged had physician orders for two hour checks post hospitalization.

  Tenant #2, an 86 year old, was admitted on 3-12-14 and diagnoses included: Macular Degeneration of Retina, Type II Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Depression, Atrial Fibrillation and Gastric Esophageal Reflux Disease. According to a Daily Communication Note dated 7-28-14 for the 3-11 Shift, Tenant #2 returned from the hospital at 6:00 p.m. Tenant #2 and a nurse requested Tenant #2 be checked on throughout the night as Tenant #2 was not able to walk alone. The Daily Communication Sheet dated 7-28-14 for the 11-7 Shift indicated Tenant #2 was checked on at midnight and was okay. Tenant #2 was checked on at 3:05 a.m. and Tenant #2 stated Tenant #2 had been sleeping and thanked staff for coming to check on Tenant #2. The Daily Client Communication Sheet dated 7-29-14 for the 7-3 Shift indicated during the morning visit Tenant #2 started swearing at Staff #1 and was very demanding and wanted help changing the protective undergarment and fixing Tenant #2's breakfast. Staff #1 told Tenant #2 this would be a Care Call and Tenant #2 refused and started swearing again and did not want the cares completed. Staff #1 notified the DON. The next note on the Daily Client Communication Sheet indicated a Care Call for Tenant #2 who needed help changing the protective undergarment. Tenant #2 was soaked up to his/her back and was cleaned up.

Staff #1 was interviewed and stated Tenant #2 returned to the Program the night before. She checked in on Tenant #2 and he/she wanted the protective undergarment changed. She didn't know that service was needed and told Tenant #2 it would need to be added to the Care Plan and she would need to ask the DON before doing it. Tenant #2 also wanted her to fix breakfast and started cursing at her. She left and went to tell the DON who went to Tenant #2's apartment.

The DON was interviewed and stated she received a phone call from Staff #1 at 8:30 a.m. regarding Tenant #2's request for services. She went to see Tenant #2 to see if additional services were needed. Staff #1 had reported Tenant #2 wanted her to make Tenant #2's breakfast and she did it even though it was not on the care plan. Tenant #2 told her he/she didn't think he/she should pay for the care calls and apologized for cursing at Staff #1. Tenant #2 didn't mention anything about needing protective undergarments changed.

A Daily Client Communication Sheet dated 7-29-14 for the 7-3 Shift indicated Tenant #2 needed help changing protective undergarment and was cleaned up and on 7-29-14 for the 3-11 shift, indicated Tenant #2 pressed pendant and requested protective undergarment changed. Tenant #2 was cleaned up, extremities cleaned, refused to have sponge bath. At 8:36 p.m. the protective undergarment was changed and Tenant #2 got ready for bed, said he/she was okay. A Daily Client Communication Sheet dated 7-29-14 for the 11-7 shift indicated Tenant #2 pushed pendant at 12:10 a.m. Staff responded and found Tenant #2 very flushed in the face. Tenant #2 said lips and fingers were numb and Tenant #2 could not move them and had a hard time staying awake. The ambulance was called and Tenant #2 was transported to the hospital. The DON was called and Tenant #2's contact was called and messages were left. The Emergency Room nurse called and stated Tenant #2 needed more care than the Program could provide and would be going to a rehab center.

Tenant #2 was not at the Program during the monitoring investigation and could not be interviewed.

Review of Tenant #2's file, review of Daily Client Communication Sheets, interviews with Staff #1 and the DON indicated Tenant #2 requested to be checked on during the night and night checks were completed and protective undergarments were changed when requested.

- Regulatory Insufficiency: None noted.

C. Structural Requirements

Complaint/Incident Allegation #49067-C: It was alleged there were ants in a tenant apartment and an exterminator was not allowed to treat the problem.

- Monitoring Observation:

The Maintenance Supervisor was interviewed and stated there had been problems with ants. A pest control company came monthly and sprayed the building. He stated Tenant #1 had complained about ants mid-way between the pest control

company's visits and Tenant #1 stated Tenant #1 had seen ants. Tenant #1's family also mentioned the ants. The Maintenance Supervisor sprayed the apartment and it took care of the problem. He said he did not see any ants in the apartment. He also set up bait traps in Tenant #1's room on the same day Tenant #1's family said family saw ants. The Maintenance Supervisor sprayed the ants' travel point. Four or five days later Tenant #1's family asked if family could use the spray, so the Maintenance Supervisor gave family the spray can. The Maintenance Supervisor sprayed the apartment three times, two of these times were without being asked by Tenant #1 or Tenant #1's family. He saw Tenant #1 in the dining room and asked if the ants were gone and Tenant #1 replied that they were. The Maintenance Supervisor stated he had never done any wall repairs in Tenant #1's apartment.

The Maintenance Supervisor said Tenant #4 lived in the apartment now. The Maintenance Supervisor and the monitor asked Tenant #4 if they could look in the apartment to see if there were any ants. Tenant #4 stated a few ants were observed when Tenant #4 originally moved into the apartment but pest control handled it immediately and no ants had been seen since. A bait trap was kept in the kitchen but Tenant #4 stated he/she had not seen any ants since the time Tenant #4 moved into the apartment. The monitor did not observe any ants in the apartment on 7-30-14.

A community meeting was held with 22 tenants. Two to three tenants stated after the winter ended this year, approximately three months ago, they saw some ants. They showed the ants to the Administrator, the area was sprayed and there had not been any ants since that time. The tenants stated there were no issues with ants at the current time. The tenants stated they had not had any ants on their bedding or on their bodies.

Staff #2 was interviewed and stated if food was dropped on the floor, maybe once or twice this summer she had seen one or two ants in tenant apartment kitchen areas. She had never seen any ants on a tenant. She stated she cared for Tenant #1 and never saw any ants in his/her room.

The Administrator was interviewed and stated there had been ants in the building at times. They had an exterminator service and they provided a spray that could be used in between their visits. The Administrator stated there had not been ants on any of the tenants.

An email dated 11-18-13 to the Program's Executive Director from a home health nurse indicated Tenant #1's physician got back to her and the last time Tenant #1 was seen was at the end of July and there was no documentation treating Tenant #1 for bug bites. Another physician from Family Practice called back and also stated Tenant #1 was not treated for bug bites.

Tenant Meeting minutes were reviewed from 1-30-14 through 7-29-14. There were no comments discussed at the meetings in regards to ants or issues with ants.

Monthly pest control invoices were provided from 8-28-13 through 7-29-14.

Per interviews with the Maintenance Supervisor, Staff #2, Administrator and tenants at a community meeting, there were times when ants were found in several

apartments and treatment was provided immediately. Physician communications indicated Tenant #1 was not treated for bug bites. Review of pest control invoices indicated monthly pest control services were provided.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48747-C: It was alleged the carpeting in the hallway was dirty.

- Monitoring Observation: On 7-30-14 the monitor toured the building and walked the halls of all three floors of the Program. The carpets in the hallways were noted to be clean and without any dirty spots.

  The Maintenance Supervisor was interviewed and stated the hallway carpets were cleaned frequently and shampooed every six months. He would clean more frequently if he saw an area that needed cleaning. He stated he had not received any complaints from the tenants regarding the hallway carpets being dirty or needing to be cleaned.

  The Administrator was interviewed and stated the hallway carpets were shampooed at least two times per year.

  A community meeting was held with 22 tenants and they stated the hallway carpets were vacuumed one time a week and shampooed every six months.

  Per observations and interviews with the Maintenance Supervisor, Administrator and tenants at a community meeting, hallways were vacuumed and shampooed on a regular basis and no dirty areas were noted in the hallways.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48747-C & #49209-C: It was alleged ceiling panels were missing and a bucket was catching water leaking from a pipe. It was alleged copper pipes leaked for a year, were colored green and a copper elbow was not replaced when the leak was fixed.

- Monitoring Observation: On 7-30-14 the monitor toured all three floors of the building and did not note any missing ceiling tiles. One new ceiling tile was observed in place near the elevators where the Administrator stated there had been a leaky pipe. The ceiling tile was removed so the monitor could observe the area that had been leaking and observed the copper pipes in the ceiling. No leakage was present and very little green oxidation was noted on the three copper pipes in the area, including a copper elbow.

  The Maintenance Supervisor was interviewed and stated he had noticed a water leak coming from the ceiling as the ceiling tile had a bulge and a drop of water dripped about every four minutes. He stated he had to find a mechanical plumber to fix it as a regular plumber could not do the job. The replacement part was a copper elbow that was 2 ½ inches which was not a common size, thus it took one week to get it fixed

due to needing time to find the part. In the meantime, he placed a bucket to catch the drips and put up two signs on each side of the bucket that indicated caution. This occurred approximately six weeks earlier and he received no complaints from any tenants about the leak or the bucket. He stated currently there were no leaky pipes and no major repair issues or concerns at this time.

The Administrator was interviewed and stated there had been a leak by the elevator in the hallway and it took about two weeks to resolve the issue. It appeared to be leaking from the elbow but the leak was actually coming from another area.

A community meeting was held with 22 tenants and when asked if there were any issues with leaky pipes, the tenants responded there were no issues.

The Program provided a statement that indicated on approximately 6-23-14, the plumbing company replaced an elbow above the first floor hallway ceiling. In doing so they found a connection close to the elbow was the cause of the drip and the connector was also replaced. The Program provided a copy of the plumbing company's invoice dated 8-1-14 for the supplies used, including eight hours of labor to fix a water line repair.

Per observations, interviews with the Maintenance Supervisor, the Administrator and tenants at a community meeting and review of a plumbing invoice, there had been a leak in the ceiling that was promptly repaired, a new ceiling tile was put in place, the copper elbow was replaced and normal green oxidation was noted.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #48747-C: It was alleged tall weeds at the corner prevented seeing clearly to the street when driving a car.

- Monitoring Observation: On 7-30-14, the monitor walked the outside property to determine clearance to the street. The monitor also exited the street via a car to determine if anything obstructed the view of the street. Due to the city's placement of a stop sign, next to the sidewalk was a light pole, then a manhole cover and finally the stop sign. If a driver stopped behind the stop sign it was impossible to see the street from either direction due to being too far back from the street. Cars were observed driving a full car length in front of the stop sign in order to turn onto the cross street. The monitor also had to drive a full car length in front of the stop sign in order to see the street. In this position, nothing obstructed the view of the street so the driver could easily turn either right or left without any obstruction. No tall weeds were observed on the corner. The Program's property did not obstruct the view from entering the cross street in either direction.

  Per observations, tall weeds were not noted and cars driving on the street could turn either direction without any obstruction from the Program's property.

- Regulatory Insufficiency: None noted.

D. Other

Complaint/Incident Allegation #49209-C: It was alleged a tenant's family member was not allowed to visit the tenant.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #3, an 87 year old, was admitted on 9-1-13 and diagnoses included: Congestive Heart Failure with Chronic Atrial Fibrillation, Peripheral Artery Disease, Type II Diabetes, Weakness, Sleep Apnea, Chronic Renal Disease and Insufficiency, Hypernatremia and a History of Alcohol Abuse. Tenant #3 did not receive any services; was independent in all services including medications.

  Tenant #3 was interviewed and stated he/she had lived at the Program for about one year and enjoyed being able to come and go as Tenant #3 pleased. Tenant #3 still drove his/her own car. Tenant #3 stated housekeeping services were satisfactory and the grounds were well maintained. Tenant #3 stated a family member had moved into the apartment for a little while but was gone now. The family member still came back to visit, was actually there earlier that morning and visited frequently, almost every day. Tenant #3 went fishing in Minnesota for a week and the family member stayed in the apartment while Tenant #3 was gone. Tenant #3 verbalized understanding of the policy regarding others not being able to move into the apartment and stated he/she was fine with the policy. Tenant #3 stated he/she did not eat at the Program; he/she either prepared his/her own food or ate out. Tenant #3 stated he/she did not have any leaky pipes and everything worked. Tenant #3 had no maintenance issues or concerns.

  The Administrator was interviewed and stated he had never denied any family from seeing a tenant. He stated he did ask Tenant #3's family to leave since the family had moved into the apartment and was staying there while Tenant #3 was out of town. Tenant #1's family moved out the day it was addressed, which was about three weeks ago. Tenant #1's family could visit Tenant #1 at any time and the family did visit.

  The Administrator provided a copy of Tenant #3's signed Lease Agreement, as well as Tenant Rules and Regulations that were part of the Occupancy Agreement. Under "General Restrictions" it stated a tenant may have house guests for reasonable stays. A reasonable stay shall not exceed two consecutive days (without management permission) nor an aggregate of fourteen (14) days total in any one year period. A copy of Tenant #3's Occupancy Agreement was provided dated 8-29-13 by Tenant #3 and the Administrator.

  Per interviews with Tenant #3 and the Administrator, Tenant #3's family had moved into Tenant #3's apartment in violation of the Occupancy Agreement and moved out when asked to do so by the Administrator. Tenant #3 and the Administrator acknowledged Tenant #3's family was allowed to visit at any time and did visit when desired.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #49067-C: It was alleged a tenant was billed for service calls by the home health agency when the tenant was out of the program.

- Monitoring Observation: Three tenant files were reviewed.

  According to Tenant #1's Coordination of Care Notes, Tenant #1 was admitted to home health services on 7-12-13. On 8-21-13 the home health agency was notified that Tenant #1 was hospitalized. Tenant #1 returned from the hospital on 8-24-14 and declined readmission to home health as family was providing services. On 9-12-14 Tenant #1's family was unable to provide services and arrangements were made for a home health referral for bathing and homemaking. Family would continue to set up medications and dressing changes to right foot.

  Care Call Notes dated 9-22-13, 9-25-13, 9-26-13, 9-27-13, 9-28-13 and 9-29-13 indicated morning medication reminders and 9-26-13, 9-27-13, 9-28-13, 9-29-13 and 9-30-13 indicated evening medication reminders and on 10-1-14 at 9:15 a.m. indicated morning medication reminder for a total of 11 Care Calls in September 2013 and 1 Care Call in October 2013.

  According to the Coordination of Care Notes dated 10-1-14 Tenant #1 was found in the back of the building in the rocks. Tenant #1 stated he/she was walking with a walker and the walker went off the sidewalk. With the assistance of a nurse and the Administrator, Tenant #1 was assisted up into a seated walker. Tenant #1 declined any pain before moving and had an abrasion on the right hand cleaned with soap and water and bandage applied. Tenant #1 was assisted to lie down in bed and stated he/she would lie down for 10 to 20 minutes and then get up. Tenant #1 declined any shortness of breath or chest pain. According to the Coordination of Care Notes dated 10-2-13, Tenant #1 was admitted to the hospital. On 10-3-13 Tenant #1 was admitted to the Intensive Care Unit. On 10-24-13 Tenant #1 was admitted to a nursing home and rehab center. According to the Coordination of Care Notes dated 11-16-13 Tenant #1 passed away.

  Invoices were requested for service calls from June 2013 through October 2013 for Tenant #1. The home health agency provided a statement indicating there were no services provided for the months of June, July and August 2013 so no invoices were created for those months. An invoice for September 2013 indicated a monthly service plan fee plus 22 care calls. An invoice for October 2013 indicated a pro-rated monthly service plan fee. The October invoice indicated the charges for September 2013 were past due. As of 8-4-14, no payment had been received for the September and October 2013 charges.

  Review of Tenant #1's file indicated documentation of 11 care calls for medication reminders. The home health agency was asked for documentation of the additional 11 care calls reflected on the invoice for 22 care calls. Per the DON, documentation for the additional 11 care calls could not be located, thus the invoice was corrected to reflect only 11 care calls. A copy of the corrected invoice was provided.

Review of documented care calls and invoices from the home health agency for Tenant #1 did not reflect charges for care calls when Tenant #1 was out of the program.

- Regulatory Insufficiency: None noted.