IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED

December 15, 2011

Ms. Bonnie Winger, Administrator
Rose of Des Moines
1330 19th Street
Des Moines, IA 50314

RE: I. Final Recertification Monitoring Evaluation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Ms. Winger:

I. Final Recertification Monitoring Evaluation Report – Rose of Des Moines, Des Moines, IA

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Criteria for Exclusion of Tenants, Service Plan, Staffing, and Program Notification to the Department. Rose of Des Moines("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

DIA is accepting the Plan of Correction (POC) following the Program's submission of information.

The Request for Reconsideration is accepted in the area of DAA Abuse Training. The Request for Reconsideration is denied in the areas of Level of Care as the program retained a tenant that was a danger to herself and Notification to the Department as program failed to notify the Department after an accidental overdose led to a hospitalization. The Final Report is enclosed.

II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send cover letter to the attention of **Rose Boccella** and remit the penalty assessed by check or money order in the amount of six hundred and fifty dollars($650) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0223** with effective dates of **December 5, 2011** through **December 4, 2013**.

V. Conclusion

The Program is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The POC submitted on December 8, 2011, has been reviewed and will constitute the final POC related to the on-site visit of October 18 and 19, 2011. The Request for Reconsideration is accepted in the area of DAA Abuse Training. The Request for Reconsideration is denied in the areas of Level of Care as the program retained a tenant that was a danger to herself and Notification to the Department as program failed to notify the Department after an accidental overdose led to a hospitalization. The Final Report is enclosed.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to this letter and report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Bonnie Winger, Administrator
Rose of Des Moines
1330 19th St.
Des Moines, Iowa 50314

Date of Monitoring Visit:

October 18 and 19, 2011

Monitor(s):

Maribeth Freland RN
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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	51
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	51
TOTAL census of Assisted Living Program	51

Tenant/Family Satisfaction Results – A community meeting was held with ten tenants in attendance. The tenants reported general satisfaction with the program. They reported respectful staff interaction and timely response to calls made using emergency pendants. The tenants reported the food served by the program was palatable and the provision of scheduled activities plentiful. They reported the program's environment to be clean and safe, acknowledging they would recommend the program to others.

Program History – The program had no regulatory insufficiencies this certification period.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

A. Evaluation of Tenant

- Monitoring Observation: Tenant #1 (the Tenant), a 58 year-old, had an admission date of 9-29-10 and documented diagnoses of: Diabetes, Neuropathy, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and Fibromyalgia. On 9-8-11, the Tenant answered all answers on the Mental Status Questionnaire (MSQ) correctly, indicating no cognitive impairment.

  On 8-30-11, a registered nurse completed an evaluation of the Tenant's health and functional status after the Tenant took too much medication, requiring medical evaluation and hospital admission. The nurse did not complete an evaluation of the Tenant's cognitive status.

  Tenant #3 (the Tenant), a 73 year old, had an admission date of 5-26-11 and documented diagnoses of: Adult Failure to Thrive, Debility, Depression, Diabetes, Hypertension (HTN) and Alcohol Dependence. The Tenant scored three on the Global Deterioration Scale (GDS), indicating mild cognitive decline. A registered nurse completed a 30-day evaluation of the Tenant's health and functional status on 5-26-11; however, the nurse did not document any updated vital signs, weight, lung sounds or bowel patterns. The same nurse did not complete a cognitive evaluation at this time.

Tenant #4 (the Tenant), a 76 year-old, had an admission date of 3-4-11 and documented diagnoses of: HTN, Obsessive-Compulsive Disorder, Chronic Anxiety, Hypothyroidism, and Parkinsonism. A registered nurse completed a 30-day evaluation of the Tenant's health and functional status on 3-4-11, but a cognitive evaluation was not completed at this time.

Tenant #6 (the Tenant) a 76 year-old, had an admission date of 9-1-10 and documented diagnoses of: Osteoarthritis, Diabetes Mellitus Type II, Neuropathy, and Macular Degeneration. A registered nurse completed a 30-day evaluation of the Tenant's health and functional status on 9-2-10, but a cognitive evaluation was not completed at this time.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Criteria for Exclusion of Tenants

- Monitoring Observation: Tenant #1 (the Tenant) had a documented past history of abuse of prescription pain medications as recent as 2009. Upon admission to the program on 9-29-10, the Tenant's physician set up a system allowing the Tenant to administer his/her own medications with a selected pharmacy delivering daily a one day supply of medications. The pharmacy only delivered Monday through Friday; therefore, the pharmacy delivered Saturday, Sunday and Monday morning medications to the Tenant on Fridays as well. The program allowed the Tenant to keep all of the delivered weekend medications in his/her own room and self-administer the medications independently. Tenant #1 took Dilaudid, Morphine and Vicodin , all narcotic pain medications; Sertraline, an antidepressant; Seroquel, an antipsychotic; and Lorazepam, a benzodiazepine sedative.

  On Saturday 8-27-11 at 1:50 PM, Staff #2, a home health aide, found the Tenant in his/her apartment unresponsive. Staff #2 contacted Staff #10, a registered nurse, who immediately came to the program to assess the Tenant. The nurse found the Tenant to be unresponsive, unable to stand independently and with garbled speech. The nurse observed a paper bag from the pharmacy sitting on the floor beside the bed. All medication planners and prescription bottles for Saturday, Sunday and Monday morning were empty. Emergency services were summoned with the Tenant being transported to the hospital via ambulance. Emergency services found the Tenant to be unresponsive with a peripheral oxygen level of 70 percent and a carbon dioxide level of 69 percent. The Tenant was immediately transported to the hospital.

  Tenant #1 presented at the hospital with mental bluntness and acute respiratory failure with associated acute respiratory acidosis. The Tenant received Narcan, a drug used to counteract the effects of narcotic overdose, and was subsequently admitted to the intensive care unit for non-invasive ventilation and close monitoring. The Tenant

denied attempt at suicide, citing accidental ingestion as the cause of his/her overdose. The Tenant later reported taking two Dilaudid tablets and two Morphine tablets at the same time. He/she was very upset with hospital staff for administering the Narcan. The Tenant returned to the program on 8-28-11 at approximately 12:00 Noon.

On Sunday 9-11-11, Staff #5, a home health aide, documented finding Tenant #1 at the dining room table lying asleep with his/her hands and face in the plate full of food. Staff #5 cleaned the Tenant's face and hands and assisted him/her to go to the apartment to lie down. The staff member called the registered nurse on call to report the Tenant's condition. The clinical record lacked any documentation of nurse follow up.

On Saturday 9-17-11, Staff #2, a home health aide, noted extreme lethargy documenting "kind of out of it again." The staff member called Staff #9, the Tenant's case manager/registered nurse to report the Tenant's condition. The clinical record lacked any documentation of nurse follow up.

On Sunday 10-16-11, the Tenant reported over the weekend a visitor came into his/her apartment and took the bag of medications delivered by the pharmacy. The Tenant requested the visitor return the medications and the visitor complied however had removed all of the prescription narcotics from the bag. Police were notified however the Tenant refused to identify the visitor.

The program allowed the Tenant to continue to handle his/her medications independently on the weekends despite multiple episodes of change in cognition when the Tenant had access to three days worth of medications.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

C. Service Plan

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5 and #6. None of the tenants' clinical records contained documentation of identification of the tenants' preference of nursing facility should nursing facility care be required while residing at the program.

  Tenant #1's (the Tenant) service plan, dated as initiated on 11-5-10 and updated on 6/10/11, documented the Tenant was independent with bathing, grooming, dressing, toileting, transfers and mobility. The home health aide assignment directed program

staff members to assist the Tenant with bathing, perineal cleansing, oral hygiene, hair care, skin care, dressing and transfers. Home health aide visit notes documented the aides routinely assisted the Tenant with all of the assigned tasks. The service plan failed to accurately reflect Tenant #1's functional needs.

Tenant #4 (the Tenant), had documented diagnoses of Obsessive-Compulsive Disorder and Chronic Anxiety. Visit notes from 8-9-11 revealed the Tenant was having an anxiety attack. The Tenant was encouraged to verbalize concerns. Visit notes from 8-12-11 revealed the Tenant was "very anxious on a daily basis," and required redirection often to decrease the anxiety level. Visit notes from 9-9-11 revealed the Tenant was "very anxious and angry." The service plan did not identify interventions for anxiety.

Tenant #5 (the Tenant), a 79 year-old, had an admission date of 11-7-08 and documented diagnoses of: Osteoporosis, Rheumatoid Arthritis, Osteoarthritis, Depression, Anxiety, and Knee Pain. Visit notes from 7-18-11 revealed the Tenant was instructed on breathing techniques for relaxation as an adjunct to medication. Visit notes from 7-25-11 to 8-15-11 revealed the Tenant was experiencing pain, sometimes described as "mucho pain." The service plan did not identify interventions for pain including breathing techniques for relaxation. The service plan initiated 11-11-10 and updated on 7-11-11 documented the Tenant was independent with continence needs and medications. The home health aide assignment directed program staff members to remind the Tenant to take medications and assist with the application of incontinence products. Home health aide visit noted documented medication reminders, assistance with eye drops, application of salve to knees, and the application of incontinence products. The service plan did not meet the identified needs of the Tenant.

Tenant #6 was admitted to the hospital due to "5+ pitting edema in bilateral feet and lower legs. The Tenant returned to the Program on 9-26-11 with discharge instructions for daily weights. A care note dated 9-27-11 revealed the Tenant had no edema. A Visit note dated 10-10-11 revealed the Tenant had 3+ edema in both feet, and home health aides were applying leg wraps in the morning. The home health aide assignment directed program staff members to remind the Tenant to take medications. The service plan initiated 11-26-10 and updated 10-10-10 revealed the Tenant was independent with medications and did not identify the application of daily leg wraps or daily weights. The service plan did not meet the identified needs of the Tenant.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)e.)

D. Staffing

- Monitoring Observation: The program identified the Director of Home Health Services as the delegating registered nurse. The Director of Home Health Services had not attended the required Iowa rules and law training. The program did not have at least one registered nurse that had attended the training. The program employed eight home health aides. Seven of the home health aides are not currently certified as nurse aides in the state of Iowa.

- Regulatory Insufficiency: All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule. (IAC r. 481-69.29(6))

E. Program Notification to the Department

- Monitoring Observation: Tenant #1 (the Tenant) had a documented past history of abuse of prescription pain medications as recent as 2009. The program allowed the Tenant to keep all of medications in his/her own room and self-administer the medications independently. Tenant #1 took Dilaudid, Morphine and Vicodin , all narcotic pain medications; Sertraline, an antidepressant; Seroquel, an antipsychotic; and Lorazepam, a benzodiazepine sedative.

  On Saturday 8-27-11 staff members found the Tenant in his/her apartment unresponsive. A registered nurse, immediately came to the program to assess the Tenant. The nurse found the Tenant to be unresponsive, unable to stand independently and with garbled speech. The nurse observed a paper bag from the pharmacy sitting on the floor beside the bed. All medication planners and prescription bottles were empty. Emergency services were summoned with the Tenant being transported to the hospital via ambulance. Emergency services found the Tenant to be unresponsive with a peripheral oxygen level of 70 percent and a carbon dioxide level of 69 percent. The Tenant was immediately transported to the hospital. According to the Incident Report, dated 8-27-11, indicated Staff #10, registered nurse, called the hospital emergency department at 5:00 PM, receiving notification of the suspected diagnosis of medication overdose.

  Tenant #1 presented at the hospital with mental bluntness and acute respiratory failure with associated acute respiratory acidosis. The Tenant received Narcan, a drug used to counteract the effects of narcotic overdose, and was subsequently admitted to the intensive care unit for non-invasive ventilation and close monitoring. The Tenant denied attempt at suicide, citing accidental ingestion as the cause of his/her overdose. The Tenant returned to the program on 8-28-11 at approximately 12:00 Noon. The

program did not seek emergency department or hospital admission documentation upon the Tenant's discharge.

The Administrator, the Executive Director of the Roses and the Director of Home Health all reported a belief that the program would not have been required to report Tenant #1's incident occurring on 8-27-11 as the program reportedly did not know for sure that the Tenant took an overdose of medications and all three believed the Tenant had not been admitted to the hospital but kept only for observation.

The program failed to notify the Department of Inspections and Appeals within 24 hours of the Tenant's medication overdose requiring admission to the intensive care unit of the hospital.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. A. "Major injury" shall be defined as any injury which: (1) results in death; or (2) Requires admission to a higher level of treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician's extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based on the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis. (IAC r. 481- 67.4(1)a.(2))