IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 39018-C

June 19, 2012

Ms. Angela Adams, Administrator
Rose of Des Moines
1330 19th Street
Des Moines, IA 50314

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Adams:

I. Final Complaint/Incident Investigation Report – Rose of Des Moines, Des Moines, IA

Enclosed is the **Final Complaint/Incident Investigation Report** 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. The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Admission and Retention, Tenant Rights, Evaluation and Service Plans. **Rose of Des Moines** ("Program") is being assessed a $1500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 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 civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—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 a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of nine hundred seventy five dollars ($975) 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 thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $1500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on June 18, 2012, has been reviewed and will constitute the final POC related to the on-site visit of May 21, 22 and 23, 2012. The Request for Reconsideration has been denied due to tenants who exceeded level of care were retained for lengthy periods of time.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal 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 enclosed 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 Complaint/Incident Investigation Report

Assisted Living Program:

Rose of Des Moines
Angela Adams, Administrator
1330 19th St.
Des Moines, Iowa 50314

Complaint/Incident Intake #:

39018-C

Date of Complaint/Incident Investigation:

May 21, 22 and 23, 2012

Monitor(s):

Maribeth Freland RN

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:	50
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	50
TOTAL census of Assisted Living Program	50

Program History – The program received regulatory insufficiencies in the areas of: Evaluation, Service Plan, Criteria for Exclusion of Tenants, Staffing and Program Notification to the Department (medication overdose) during the Recertification on-site of October 18 and 19, 2011.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged one or more tenants continued to reside at the program when they exceeded the level of care allowed for assisted living programs.

- Monitoring Observation: The monitor reviewed the clinical records of Tenants #1, #2, #3 and #4, all tenants identified by the program as experiencing level of care concerns. All four tenants no longer resided at the program.

  Tenant #1, a 54 year old, was admitted to the program on 3-30-06 with the diagnoses of: Polyarticular Arthritis; Hypothyroidism; Esophageal Dysplasia and History of Bilateral Hip and Knee Replacements. Tenant #1 answered all questions on the Mental Status Questionnaire (MSQ) completed on 12-19-11, indicating no cognitive decline. The service plan, dated 1-12-11, indicated Tenant #1 was independent with transfers, bathing, grooming, dressing, toileting and medication administration. Tenant #1 ambulated independently in his/her apartment and used a motorized scooter for mobility outside of the apartment. The clinical record did not include any nurse evaluations or updates to the service plan after 1-12-11.

  Tenant #1's clinical record included a Consensus Based Managed Risk Agreement, dated 1-27-11. The agreement documented Tenant #1 was determined to exceed assisted living level of care citing unmanageable incontinence as evidenced by Tenant #1 leaving incontinence products scattered in the apartment causing very strong odors and allowing urine soiled clothing to remain unlaundered. The Agreement required Tenant #1 to void every two hours, change soiled incontinence products and place in the trash, independently perform perineal care following incontinent episodes, allow

trash to be removed daily and allow soiled bedding/clothing to be removed from the apartment for laundering as needed. Tenant #1 signed the Agreement and was allowed to remain at the program. In February 2011, program staff members determined Tenant #1 had complied with the Agreement, resulting in management of his/her incontinence.

The clinical record indicated Tenant #1 began experiencing unmanageable incontinence again beginning in July 2011. Tenant #1's apartment was again noted to exhibit very strong urine odor. On 7-12-11, staff members noted feces on the apartment floor, dried feces on Tenant #1's legs with clothing stuck in the dried feces. On 7-14-11 program management met with Tenant #1 to review reports of unmanaged incontinence and feces and urine on Tenant #1's clothing and bed linens. Home health documents indicated staff members assisted Tenant #1 with bathing and personal cares from July to January 2012. The program's service plan did not document bathing assistance and assistance with personal care as an individualized need of Tenant #1.

During interview, Staff #1 and Staff #2, both home health aides (HHAs), reported Tenant #1 experienced unmanageable incontinence for several months prior to moving out. Both reported Tenant #1 urinated in incontinence products and left the soiled products scattered about the apartment, soaked the bed with urine frequently and could be noted frequently to smell of urine and have urine soaked clothing on. The foul odor in Tenant #1's apartment drifted into the common hallway of the program and at times other tenants were offended by the smell. Staff #2 reported she would assist Tenant #1 with perineal cleansing, changing of clothing and incontinence products and disposal of the incontinence product when finding Tenant #1 soiled or when he/she requested assistance. Both staff members denied ever being directed to assist Tenant #1 with toileting needs.

60 Day Summaries, sent to Tenant #1's physician on 9-21-11 and 11-20-11, indicated Tenant #1 experienced incontinence that was poorly managed from July 2011 through November 2011. Coordination of care notes indicated Tenant #1's apartment continued to smell strongly of urine which permeated into the hallway outside of the apartment and staff members continued to find incontinence products soiled with urine and feces scattered around the apartment. Tenant #1 was noted to have urine soaked clothing frequently and Tenant #1's bed was frequently found to be soaked with urine, at times appearing to have been that way for several days. The program gave a 30 day notice to vacate his/her apartment on 12-19-11. Tenant #1 moved out of the apartment on 1-9-12.

The Home Care Clinical Manager reported the home health agency that provides all nursing and medical care to the program's tenants cannot provide routine toileting assistance due to regulatory allowances. He indicated if a tenant required such assistance, it would exceed the required intermittent status allowed by the home health agency.

Tenant #1's clinical record documented a need for assistance with incontinence management. The program did not provide assistance to manage the incontinence. Tenant #1 did not independently perform adequate incontinence care. Staff members and other tenants were offended by the smell of Tenant #1's apartment and person

when soiled. Tenant #1 experienced unmanaged incontinence and remained residing at the program from July 2011 until January 2012. Tenant #1 exceeded assisted living level of care.

Tenant #2, a 63 year old, was admitted to the program on 9-4-10 with diagnoses of: Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Diabetes and Anxiety. Tenant #2 scored between 3 and 4 on the Global Deterioration Scale (GDS) completed on 2-9-12, which indicated moderate cognitive decline. The service plan, dated 2-17-12, indicated Tenant #2 was independent with bathing, hygiene, dressing and managing his/her incontinence.

Tenant #2's clinical record documented Tenant #2 began experiencing unmanageable incontinence of the bowels in early December 2011. Staff members found Tenant #2's apartment smelling of foul bowel movement odors and noted Tenant #2's apartment and clothing to be covered in feces on multiple occasions beginning December of 2011 and continuing until 3-10-12, at which time Tenant #2 moved to a long term care facility. Tenant #2 experienced an inability to independently cleanse following bowel incontinence and was noted to leave the feces on items in the apartment without attempting to clean them. In early February, Tenant #2 began urinating on the floor.

Staff #1 and #2, both HHAs, reported Tenant #2 exhibited unmanageable bowel incontinence for several weeks prior to moving from the program. The foul odor in Tenant #2's apartment drifted into the common hallway of the program and at times other tenants and visitors were offended by the smell. Both staff members denied ever being directed to assist Tenant #2 with bathing, hygiene or toileting needs.

On 2-10-12 the program administration initiated a Consensus Based Managed Risk Agreement which required Tenant #2 to clean up the apartment within 3 days, wear incontinence products and change the product when soiled, will independently perform perineal cleansing following incontinent episodes and assisted living personnel would call Tenant #2's apartment every two hours for one week to remind Tenant #2 to go to toilet or change his/her incontinence product.

During interview, the Nurse Coordinator concurred with the above stated findings, indicating Tenant #2 had experienced a change of condition in early December 2011. The Nurse Coordinator reported Tenant #2 began requiring assistance with hygiene, bathing and toileting but did not receive these services as Tenant #2 did not have a funding source to pay for such services. The Nurse Coordinator indicated she offered assistance with these tasks but Tenant #2 refused to accept them. The monitor did not find this documentation in the clinical record. The Nurse Coordinator reported she contacted Tenant #2's family member after initiating the managed risk agreement. The family member visited on 2-13-12 and cleaned the apartment thoroughly and deodorized the apartment. Tenant #2 was in the apartment for several days without having noted feces on the floor or other items. Within four days, the apartment had a general foul odor again. The Nurse Coordinator reported Tenant #2 went to stay with the family member for a few days and exhibited unmanaged incontinence in the family member's home. The Coordinator could not recall the exact date. The family member sought a higher level of care for Tenant #2 and did not return Tenant #2 to the assisted living program.

Tenant #2's clinical record documented his/her need for assistance with bathing, hygiene and incontinence management. The program did not assist Tenant #2 with bathing or hygiene as he/she was unable to pay for such services. The program did not provide assistance to manage the incontinence. Tenant #2 did not independently perform adequate bathing, hygiene or incontinence management. Staff members and other tenants were offended by the smell of Tenant #2's apartment and person when soiled. Tenant #2 experienced unmanaged incontinence and remained residing at the program from December 2011 until March 2012. Tenant #2 exceeded assisted living level of care.

Tenant #3, a 77 year old, was admitted to the program on 3-4-11 with the diagnoses of: HTN, Parkinson's Disease, Anxiety Disorder and Obsessive-Compulsive Disorder. Tenant #3 answered all but one question correctly on the MSQ completed on 2-22-12, indicating no cognitive decline. The service plan, dated 2-28-12 and updated 3-6-12, indicated Tenant #3 was independent with transfers, bathing, grooming, dressing, toileting and medication administration but did require staff members to remind Tenant #3 to groom, dress and bath routinely.

Care coordination notes and documentation completed by the program's nurses indicated Tenant #3 began experiencing increased anxiety levels in mid-January 2012 such as; poor personal hygiene and inability to keep the apartment clean. Tenant #3 also quit going to meals in the program's common dining room, began losing weight and was noted to leave food items on the counter of the apartment to spoil.

In early February 2012, Tenant #3 began showing agitation with other tenants and staff members. Tenant #3 began expressing a fear of going into his/her apartment for greater than 10 minutes as this would cause illness. On one occasion, Tenant #3 expressed a wish to go to the local YMCA to spend the night so he/she did not have to enter the apartment.

In late February 2012, Tenant #3 began experiencing nausea and an inability to sit still. Tenant #3 showed extreme anxiety on a daily basis and increased agitation with staff members. Tenant #3 refused to talk with some staff members of the program with no justifiable basis. Tenant #3 began experiencing fine tremors and obsessive thoughts related to his/her bowels.

In early March 2012, Tenant #3 had two episodes of "blacking out", showed increased pacing and repetitive actions and began thinking about having sex with his/her family members with no justifiable basis for these thoughts. These thought occurred when Tenant #3 picked up a glass to take a drink. Tenant #3 reported a belief that hospital staff "will kill me" if taken to the hospital. Tenant #3 began requiring frequent redirection when in his/her apartment and in common areas of the program.

In mid-March 2012, Tenant #3 had one episode of sitting out in the common areas of the program with a bathrobe on, exposing his/her bare legs, which made other tenants uncomfortable. Tenant #3 reported having headaches. Tenant #3 became increasingly unkempt and left the apartment extremely dirty with garbage overflowing.

In late March 2012, Tenant #3 began experiencing sleep difficulties and was noted to have "out of control" obsessive-compulsive thoughts and behaviors. Tenant #3 began using excessive laxatives related to the obsession with bowel movements and urinated in the program common hallways on one occasion.

In early to mid-April 2012, Tenant #3 had another incident of entering the common hallway with only a bathrobe on. Tenant #3 appeared to be naked underneath and held the robe open exposing private areas. Tenant #3 exhibited repetitive pacing and other actions and talked of punishing him/herself. Tenant #3 called 911 once to request nurse assistance on 4-13-12. The same day Tenant #3 became agitated with the program manager and abruptly left the program grounds in his/her car. On 4-14-12, program administration gave Tenant #3 verbal notice of a three day involuntary discharge but did not give written discharge at that time. Later in the day, Tenant #3 again called 911. Tenant #3 was agitated, restless, pacing and expressed a wish to be taken to the hospital stating, "I can't take it anymore." Tenant #3 transferred from the program to a higher level of care without ever returning to the program.

On 3-6-12 the program received by facsimile documentation of Tenant #3's therapy sessions. The notes summarized the following: 1-13-12- Tenant #3 exhibited excessive worrying and punished self for past indiscretions. 1-20-12- Tenant #3 exhibited increased anxiety, repetitive storytelling, expressed multiple sexual fantasies and hopped from topic to topic with no relationship between topics. 1-26-12- Tenant #3 talked obsessively of thoughts of having sex with family members which were illogical in nature and reported engaging in obsessional rituals which made him/her feel as if in a trance. 2-10-12- Tenant #3 exhibited a flat affect and presented with staring throughout appointment. 2-14-12- Tenant #3 appeared unkempt, unshaven and had on dirty clothes. Tenant #3 had rambling thoughts, repetitive statements, appeared highly anxious and appeared to be panicked. 3-2-12- Tenant #3 appeared unkempt, long dirty fingernails and had on the same dirty clothes worn at the last session (which was 2 weeks prior). Tenant #3 jumped from topic to topic and reported he/she was scared but could not identify the reason. Tenant #3 talked of having a fear of his/her assisted living apartment and reported being in the apartment caused nausea.

On 3-15-12 the program administration attempted to present Tenant #3 with a Consensus Based Managed Risk Agreement which required Tenant #3 to accept a bath aide twice weekly, accept a homemaker for cleaning weekly and agree to eat lunch in the common dining room. Tenant #3 showed agitation during the meeting and the document was not signed by Tenant #3 or any administration. Tenant #3 continued to reside at the program.

Tenant #3 exhibited progressively worsening acute mental illness from mid-January 2012 to mid-April 2012 while residing at the program. The program nurses and management were aware of Tenant #3's escalation in behaviors associated with his/her acute mental illness, some which involved or offended other tenants, during this three month period and allowed Tenant #3 to remain living at the program. Tenant #3 exceeded assisted living level of care.

Tenant #4, an 85 year old, was admitted to the program on 3-28-09 with the diagnoses of Diabetes and History of Pressure Sores. Tenant #4 scored a 4 on the

GDS completed on 3-21-12, which indicated moderate cognitive decline. The service plan, dated 3-21-12, indicated Tenant #4 showed a change in functional status, requiring staff members to assist Tenant #4 with bathing, grooming and dressing. The service plan indicated Tenant #4 began requiring the assistance of one staff member for transfers and ambulation. The clinical record indicated Tenant #4 had a tendency to sit in his/her chair most of the time, causing pressure sores to form on both buttocks cheeks. The wounds were chronic and were treated by Tenant #4's physician on an ongoing basis.

Tenant #4 fell while in his/her own apartment on 5-9-12, landing on the buttocks. Tenant #4 did not get injured during the fall. On 5-9-12 Staff #3, registered nurse (RN), assessed Tenant #4 approximately two hours after Tenant #4's fall. Staff #3 noted Tenant #4 to be weak, requiring two person assistance to stand from the toilet. Tenant #4 had also been incontinent of urine soaking through clothing. Staff #3 determined all of these to be out of the ordinary for Tenant #4. Staff #3 assisted Tenant #4 with removal of the soiled clothing and cleansing of the perineal area following the incontinent episode. Staff #3 reported noting dried exudates at the top of Tenant #4's buttocks area. When cleansing the area, Staff #3 noted a skin flap at the sacral area of the buttocks. The flap moved with wiping motions, revealing an open wound under the skin flap. The wound had a tract that measured 8 to 10 centimeters (cm) deep. Staff #3 immediately contacted Tenant #4's physician and then sent Tenant #4 to the emergency room for medical evaluation of the wound. Tenant #4 was subsequently admitted to the hospital and was discharged from the hospital on 5-14-12. Tenant #4 was transferred to a long term care facility as the need for treatment of the wound and Tenant #4's decreased ability to care for him/herself exceeded the assisted living level of care.

Tenant #4 did not exceed assisted living level of care prior to his/her hospitalization on 5-9-12 and did not return to the program upon hospital discharge.

- 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))

During the course of the investigation, the monitor noted the following:

B. Tenant Rights

- Monitoring Observation: Tenant #1's service plan, dated 1-12-11, indicated Tenant #1 was independent with bathing, grooming, dressing and incontinence management.

The clinical record did not include any nurse evaluations or updates to the service plan after 1-12-11.

Tenant #1's clinical record included a Consensus Based Managed Risk Agreement, dated 1-27-11. The agreement documented Tenant #1 was determined to exceed assisted living level of care citing unmanageable incontinence as evidenced by Tenant #1 leaving incontinence products scattered in the apartment causing very strong odors and allowing urine soiled clothing to remain unlaundered. The Agreement required Tenant #1 to void every two hours, change soiled incontinence products and place in the trash, perform perineal care following incontinent episodes independently and allow trash to be removed daily and allow soiled bedding/clothing to be removed from the apartment for laundering as needed. Tenant #1 signed the Agreement and was allowed to remain at the program. In February 2011, program staff members determined Tenant #1 had complied with the Agreement, resulting in management of his/her incontinence.

The clinical record indicated Tenant #1 began experiencing unmanageable incontinence again beginning in July 2011. Tenant #1's apartment was again noted to exhibit very strong urine odor. On 7-12-11, staff members noted feces on the apartment floor, dried feces on Tenant #1's legs with clothing stuck in the dried feces. On 7-14-11 program management met with Tenant #1 to review reports of unmanaged incontinence and feces and urine on Tenant #1's clothing and bed linens. Home health documents indicated staff members assisted Tenant #1 with bathing and personal cares from July to January 2012. The program's service plan did not document bathing assistance and assistance with personal care as an individualized need of Tenant #1.

During interview, Staff #1 and Staff #2, both HHAs, reported Tenant #1 experienced unmanageable incontinence for several months prior to his/her moving out. Both reported Tenant #1 urinated in incontinence products and left the soiled products scattered about the apartment, soaked the bed with urine frequently and could be noted frequently to smell of urine and have urine soaked clothing on. The foul odor in Tenant #1's apartment and drifted into the common hallway of the program and at times other tenants were offended by the smell. Staff #2 reported she would assist Tenant #1 with perineal cleansing, changing of clothing and incontinence products and disposal of the incontinence product when finding Tenant #1 soiled or when he/she requested assistance. Both staff members denied ever being directed to assist Tenant #1 with toileting needs.

60 Day Summaries, sent to Tenant #1's physician on 9-21-11 and 11-20-11, indicated Tenant #1 experienced incontinence that was poorly managed from July 2011 through November 2011. Coordination of care notes indicated Tenant #1's apartment continued to smell strongly of urine which permeated into the hallway outside of the apartment and staff members continued to find incontinence products soiled with urine and feces scattered around the apartment. Tenant #1 was noted to have urine soaked clothing frequently and Tenant #1's bed was frequently found to be soaked with urine, at times appearing to have been that way for several days. The program gave a 30 day notice to vacate his/her apartment on 12-19-11. Tenant #1 moved out of the apartment on 1-9-12.

The Home Care Clinical Manager reported the home health agency that provides all nursing and medical care to the program's tenants cannot provide routine toileting assistance due to regulatory allowances. He indicated if a tenant required such assistance, it would exceed the required intermittent status allowed by the home health agency.

The clinical record documented Tenant #1 needed assistance with incontinence management. The program did not provide assistance with incontinence management in a way to get the incontinence under control. Tenant #1 did not independently perform incontinence management adequately. Staff members and other tenants were offended by the smell of Tenant #1's apartment and person when soiled.

Tenant #2's service plan, dated 2-17-12, indicated Tenant #2 was independent with bathing, hygiene, dressing and managing his/her incontinence.

Tenant #2's clinical record documented Tenant #2 began experiencing unmanageable incontinence of the bowels in early December 2011. Staff members found Tenant #2's apartment smelling of foul bowel movement odors and noted Tenant #2's apartment and clothing to be covered in feces on multiple occasions beginning December of 2011 and continuing until 3-10-12, at which time Tenant #2 moved to a long term care facility. Tenant #2 experienced an inability to cleanse him/herself following bowel incontinence and was noted to leave the feces on items in the apartment without attempting to clean them. In early February, Tenant #2 began urinating on the floor.

Staff #1 and #2, both HHAs, reported Tenant #2 exhibited unmanageable bowel incontinence for several weeks prior to moving from the program. The foul odor in Tenant #2's apartment drifted into the common hallway of the program and at times other tenants and visitors were offended by the smell. Both staff members denied ever being directed to assist Tenant #2 with bathing, hygiene or toileting needs.

On 2-10-12 the program administration initiated a Consensus Based Managed Risk Agreement which required Tenant #2 to clean up the apartment within 3 days, wear incontinence products and change the product when soiled, will independently perform perineal cleansing following incontinent episodes and assisted living personnel would call Tenant #2's apartment every two hours for one week to remind Tenant #2 to go to toilet or change his/her incontinence product.

During interview, the Nurse Coordinator concurred with the above stated findings, indicating Tenant #2 had experienced a change of condition in early December 2011. The Nurse Coordinator reported Tenant #2 began requiring assistance with hygiene, bathing and toileting but did not receive these services as Tenant #2 did not have a funding source to pay for such services. The Nurse Coordinator indicated she offered assistance with these tasks but Tenant #2 refused to accept them. The monitor did not find this documentation in the clinical record. The Nurse Coordinator reported she contacted Tenant #2's family member. The family member visited and cleaned the apartment thoroughly and deodorized the apartment. Tenant #2 was in the apartment for several days without having noted feces on the floor or other items. Within four days, the apartment had a general foul odor again. Tenant #2 went to stay with the family member for a few days and exhibited unmanaged incontinence in the family

member's home. The family member sought a higher level of care for Tenant #2 and did not return Tenant #2 to the assisted living program.

The clinical record documented Tenant #2 needed for assistance with bathing, hygiene and incontinence management. The program did not assist Tenant #2 with bathing or hygiene as he/she was unable to pay for such services. The program did not provide assistance with incontinence management in a way to get the incontinence under control. Tenant #2 did not independently perform adequate bathing, hygiene or incontinence management. Staff members and other tenants were offended by the smell of Tenant #1's apartment and person when soiled.

- Regulatory Insufficiency: All tenants have the right to be treated with full recognition of personal dignity. (IAC r. 67.3(1))

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate. (IAC r. 67.3(2))

C. Evaluation

- Monitoring Observation: Tenant #1's clinical record included documentation of an evaluation of Tenant #1's health, functional and cognitive status completed on 1-12-11. The evaluation indicated Tenant #1 was independent with all activities of daily living (ADLs) including: bathing, grooming, dressing and toileting. The clinical record lacked any further evaluations.

  Home health documentation for Tenant #1 indicated staff members provided assistance with bathing and personal care tasks between 9-21-11 and 1-9-12, at which time Tenant #1 moved to a long term care facility. During interview, Staff #1 and Staff #2, both HHAs, reported assisting Tenant #1 with bathing prior to his/her moving out of the program. Both reported Tenant #1 experienced unmanageable incontinence for several months prior to his/her moving out. Both reported Tenant #1 urinated in incontinence products and left the soiled products scattered about the apartment, soaked his/her bed with urine frequently and could be noted frequently to smell of urine and have urine soaked clothing on. Staff #2 reported she would assist Tenant #1 with perineal cleansing, changing of clothing and incontinence products and disposal of the incontinence product when finding Tenant #1 soiled or when he/she requested assistance. The clinical record lacked evidence of health, functional or cognitive evaluations associated with the time period when the changes occurred.

  Tenant #2's clinical record included documentation of an evaluation of Tenant #2's health, functional and cognitive status completed on 3-3-11 and updated on 9-7-11. The evaluation indicated Tenant #2 was independent with all ADLs including: bathing, grooming, dressing and toileting. The clinical record lacked any further evaluations.

  Tenant #2's clinical record documented Tenant #2 began experiencing unmanageable incontinence of the bowels in early December 2011. Staff members found Tenant

#2's apartment smelling of foul bowel movement odors and noted Tenant #2's apartment and clothing to be covered in feces on multiple occasions beginning in December of 2011 and continuing until 3-10-12, at which time Tenant #2 moved to a long term care facility. Tenant #2 experienced an inability to cleanse him/herself following bowel incontinence and was noted to leave the feces on items in the apartment without attempting to clean them. In early February, Tenant #2 began urinating on the floor. Staff #1 and #2, both HHAs, reported Tenant #2 exhibited unmanageable bowel incontinence for several weeks prior to moving from the program.

During interview, the Nurse Coordinator concurred with the above stated findings, indicating Tenant #2 had experienced a change of condition in early December 2011. The Nurse Coordinator reported Tenant #2 began requiring assistance with hygiene, bathing and toileting but did not receive these services as Tenant #2 did not have a funding source to pay for such services. The clinical record lacked evidence of completion of functional, health and cognitive evaluations associated with the time period when the changes occurred.

The evaluations had not been completed for both Tenants #1 and #2 when significant changes in condition were noted by program staff members.

- 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))

D. Service Plans

- Monitoring Observation: Tenant #1's clinical record included documentation of a service plan, dated 1-12-11. The service plan indicated Tenant #1 was independent with all ADLs including: bathing, grooming, dressing and toileting. The clinical record lacked any further updates to the service plan.

  Home health documentation for Tenant #1 indicated staff members provided assistance with bathing and personal care tasks between 9-21-11 and 1-9-12, at which time Tenant #1 moved to a long term care facility. During interview, Staff #1 and Staff #2, both HHAs, reported assisting Tenant #1 with bathing prior to his/her moving out of the program. Both reported Tenant #1 experienced unmanageable incontinence for several months prior to his/her moving out. Both reported Tenant #1 urinated in incontinence products and left the soiled products scattered about the apartment, soaked his/her bed with urine frequently and could be noted frequently to smell of urine and have urine soaked clothing on. Staff #2 reported she would assist Tenant #1 with perineal cleansing, changing of clothing and incontinence products and disposal of the incontinence product when finding Tenant #1 soiled or when

he/she requested assistance. The service plan created for Tenant #1 did not reflect Tenant #1's individualized needs when these changes occurred.

Tenant #2's clinical record included documentation of a service plan, dated 2-17-12. The service plan indicated Tenant #2 was independent with all ADLs including: bathing, grooming, dressing and toileting. The clinical record lacked any further updates to the service plan.

Tenant #2's clinical record documented Tenant #2 began experiencing unmanageable incontinence of the bowels in early December 2011. Staff members found Tenant #2's apartment smelling of foul bowel movement odors and noted Tenant #2's apartment and clothing to be covered in feces on multiple occasions beginning in December of 2011 and continuing until 3-10-12, at which time Tenant #2 moved to a long term care facility. Tenant #2 experienced an inability to cleanse him/herself following bowel incontinence and was noted to leave the feces on items in the apartment without attempting to clean them. In early February, Tenant #2 began urinating on the floor. Staff #1 and #2, both HHAs, reported Tenant #2 exhibited unmanageable bowel incontinence for several weeks prior to moving from the program.

During interview, the Nurse Coordinator concurred with the above stated findings, indicating Tenant #2 had experienced a change of condition in early December 2011. The Nurse Coordinator reported Tenant #2 began requiring assistance with hygiene, bathing and toileting but did not received these services as Tenant #2 did not have a funding source to pay for such services. The service plan created for Tenant #2 did not reflect individualized needs when these changes occurred.

The service plans had not been updated to reflect identified individualized needs for both Tenants #1 and #2 when significant changes in condition were noted by program staff members.

- 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))