IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

December 31, 2013

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

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Rose of Waterloo, Waterloo, IA

Dear Mr. Bell:

Enclosed is the **Final Complaint Investigation & 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) chapters 481—67 and 481—69.

DIA has completed the review of your Plan of Correction (POC) in response to the **Preliminary Complaint Investigation & Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0266** with effective dates of **January 2, 2014** through **January 1, 2016**.

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint: 45448-C

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

Date of Monitoring Visit:

September 23 & 24, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH
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:	57
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	58
TOTAL census of Assisted Living Program	58

Tenant/Family Satisfaction Results – A meeting was held with seven tenants. During the course of the meeting, an additional seven tenants joined the meeting. The best thing about the program was that it was comfortable, provided security for families, provided privacy, and allowed tenants to come and go as they pleased. Housekeeping was completed to tenants' satisfaction in apartments and common areas. Some of the tenants would like apartments vacuumed more frequently and small things like newspapers on the floor moved for vacuuming. Tenants used a call button to request assistance. Staff members were reported to respond in five to ten minutes. Staff was described as providing good care and was kind, respectful, and helpful. The food was mostly good, with a variety of foods served. Hot foods were not always hot, but would be reheated if requested. Cold foods such as ice cream were served cold, but served early in the meal and sometimes melted by dessert time. There were not always enough participants for activities. The tenants would like more crafts and more outside groups including children's choir groups. The tenants reported feeling safe at the program, were generally satisfied, and would recommend it to others.

Program History – During the course of the Recertification visit conducted on September 23 and 24, 2013, the program received regulatory insufficiencies in the areas of: Evaluation and Service Plans.

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

A. Evaluation of Tenant

Complaint/Incident Allegation #45448-C: It was alleged a tenant knew nothing about his/her medications, had body odor and appeared he/she hadn't bathed in quite awhile. The tenant had reported staff refused to provide personal cares and medications. It was alleged family members lived with Tenant #2 and police were called multiple times related to one of Tenant #2's family members alleged drug use.

- Monitoring Observation: Five tenant files were reviewed. No issues related to evaluations for Tenant #1 were found.

  Tenant #2, an 89 year old, was admitted on 1-31-13 and had diagnoses of: Hypertension (HTN,) Diabetes Mellitus (DM) and a History of Cerebral Vascular Accident (CVA). A cognitive evaluation was completed on 8-22-13, which indicated normal cognition.

Care notes of 6-12-13 indicated Tenant #2 fell in his/her apartment. A registered nurse (RN) completed a nurse review and noted a pink area on the left knee. Tenant #2 denied any pain or need to see a physician.

Care notes of 7-10-13 indicated Tenant #2 fell in his/her apartment. Tenant #2 reported he/she had spilled juice and slipped. An RN completed a nurse review and Tenant #2 complained of left shoulder and arm pain with movement. Tenant #2 was seen in a hospital emergency room and later admitted for a fractured left Humerus.

Care notes of 7-13-13 indicated Tenant #2 was transferred from the hospital to a nursing facility for rehabilitation.

Care notes of 8-22-13 indicated the Program evaluated Tenant #2 while at the nursing facility and concluded Tenant #2 could return to the Program. On 9-5-13 Tenant returned to the Program.

Tenant #2's file indicated functional, cognitive and health evaluations were completed on 8-22-13. Evaluations indicated Tenant #2 was independent with activities of daily living (ADLs): eating, dressing and grooming, toileting, ambulation and transfer. Tenant #2 needed assistance with bathing and medication administration.

A service plan of 9-5-13 and home health care plan of 9-11-13 indicated skilled nursing services were offered twice weekly and as needed (prn) for assessment/evaluation with attention to current illness, diabetic management and monitoring, and weekly medication set-up. A health home health aide assisted Tenant #2 twice weekly with ADLs.

A monitor met with Tenant #2 in his/her apartment and noted Tenant #2 was clean, dressed appropriately and his/her apartment was neat and tidy. Tenant #2 reported he/she had moved from a two-bedroom apartment to a one-bedroom apartment when he/she returned to the Program on 9-5-13. Tenant #2 reported one family member lived with him/her but had since moved out. Tenant #2 reported staff provided personal cares, checked his/her blood sugars often and voiced no complaints.

The Program reported Tenant #2's family member did reside with Tenant #2 and had signed a lease agreement on 1-31-13, but moved out when Tenant #2 moved to a one bedroom apartment on 9-1-13. Additionally, the Program reported there was an incident where two-tubes were found in a public restroom. Police reported the tubes did not appear to be drug related and saw no reason to investigate.

Complaint/Incident Allegation #45448-C: It was alleged a tenant had cognitive issues and should be should be in a nursing home. The tenant was incontinent of bowel and bladder and there was feces on his/her apartment counters and wet incontinent undergarments "all over the place."

- Monitoring Observation: Tenant #3, an 82 year old, was admitted on 2-1-13 and had diagnoses of: a History of CVA with Seizures, Osteoarthritis, Stroke Syndrome, Vascular Dementia, HTN, Peripheral Arterial Disease, Benign Prostatic Hypertrophy and Syncope. A cognitive evaluation was completed on 8-24-13, which indicated normal cognition.

Care notes of 2-13-13 indicated staff reported Tenant #3 was unable to mange his/her incontinence. Feces were on the bed sheets and floor and Tenant #3 needed daily assistance with incontinence care. Care notes of 2-13-13 indicated the Program met with family and reported Tenant #3 had unmanageable incontinence and needed a higher level of care than the Program could provide. The Program advised family they needed to assist Tenant #3 with managing his/her incontinence and soiled incontinent products and odor control. A family member said he/she would stay the weekend and clean Tenant #3's apartment.

Care notes of 2-25-13 indicated the RN was called by staff to Tenant #3's apartment. Tenant #3 was unresponsive during a shower. The RN and staff lowered Tenant #3 to the floor. Tenant was sent to a hospital emergency room for evaluation and returned with new medication orders.

Care notes of 2-26-13 staff caught Tenant #3 as he/she was falling in the hallway. Tenant #3 was "apparently" having a seizure. Tenant #3's right foot was injured and bent to the side, but was not bleeding. Tenant #3 was sent by ambulance to a hospital emergency room for evaluation.

Tenant #3's file indicated Tenant #3 had been hospitalized from 2-26-13 through 3-1-13 due to poor circulation to a foot and two toes had to be removed. Care notes of 3-1-13 indicated Tenant #3 was to be transferred to a skilled nursing facility for rehabilitation. Care notes of 4-18-13 indicated a functional evaluation was completed which indicated Tenant #3 could not bear weight and two staff was needed to transfer routinely. Tenant #3 continued to reside at the nursing facility.

Care notes of 7-8-13 indicated the nursing facility reported Tenant #3 could return to the Program. Functional, cognitive and health evaluations were completed on 7-8-13.

A service plan of 7-8-13 indicated Tenant #3 was independent with ADLs, including eating, transfer, ambulation and toileting and needed assistance with bathing and medication administration.

Care notes of 7-10-13 indicated Tenant #3's family requested another home health agency provide assistance with ADLs. On 7-11-13 Tenant #3 returned to the Program. On 7-12-13 Tenant #3 was admitted to another home health agency. The Program did not update the service plan to reflect an outside provider was providing home health services.

Care notes of 8-9-13 indicated the Program completed a 30-day review of Tenant #3's service plan. A review of the service plan of 7-8-13 indicated no changes indicating an outside provider was providing home health services.

Care notes of 8-21-13 indicated Tenant #3 was sent to a hospital emergency for evaluation due to weakness and decline in health status. Care notes of 8-24-13 indicated Tenant #3 returned to the Program. The home health agency that had provided home health services declined to provide home health services. Tenant #3's family member was to provide personal and health related cares.

Functional, cognitive and health evaluations were completed on 8-24-13 and the service plan was updated to reflect Tenant #3's family would assist Tenant #3 with medication

administration, assistance with bathing and dressing. Tenant #4 was independent with ambulation and transfer, eating, grooming and toileting.

Care notes of 9-12-13 indicated Tenant #3's family member, who had provided personal and health related cares had been hospitalized and requested the Program to provide the cares Tenant #3 needed. Tenant #3's service plan was updated to reflect the Program would be the provider of cares.

A monitor met with Tenant #3 in the apartment. Tenant #3 was clean, dressed appropriately and was alert and oriented to time, date and place. Tenant #3's apartment was clean and tidy and no odors were present. Tenant #3 reported he received personal cares from the Program and was satisfied. Tenant #3 reported he had incontinence issues in the past but has been able to manage it by himself/herself.

Tenant #4, an 88 year-old, was admitted on 7-1-13 and had diagnoses of: HTN, Gastroesophageal Reflux Disease, Osteoporosis, and Rheumatoid Arthritis. An evaluation of health was completed on 6-12-12, prior to admission. The health form asked for documentation of vital signs including blood pressure, heart rate, and respiratory rate. The vital signs section was blank. The evaluation form was not completed.

Tenant #5, an 80 year-old, was admitted on 6-1-13 and had diagnoses of: CVA, History of Bladder Cancer, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Seizure Disorder, and HTN. An evaluation of health was completed on 4-26-13, prior to admission. The health form asked for documentation of vital signs including blood pressure, heart rate, and respiratory rate. The vital signs section was blank. The evaluation form was not completed. Tenant #5 did not have evaluations of function, cognition, or health completed within 30 days of admission.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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 services professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plan

- Monitoring Observation: Five tenant files were reviewed and no issues related to service plans were noted for Tenants #1, #2 and #3.

  Tenant #4 had evaluations of function, cognition, and health completed on 6-12-13, prior to admission. The functional evaluation indicated Tenant #4 was independent with bathing. The initial service plan indicated Tenant #4 required assistance with bathing. The service plan was not based on evaluation of function.

  Tenant #5 had evaluations of function, cognition, and health completed on 4-26-13, prior to admission. The functional evaluation indicated Tenant #4 required assistance with bathing. The service plan, dated and signed on 4-26-13 by Tenant #5 indicated bathing assistance. A

notation was made on the service plan dated 5-20-13 that Tenant #5 declined services including bathing, medication setup, housekeeping and laundry services. The service plan was not signed by Tenant #5 indicating agreement with the changes.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26 (3))