1/30/19

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0282	A. BUILDING: _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF EAST DES MOINES	1331 IDAHO STREET DES MOINES, IA 50316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments 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. Number of tenants without cognitive disorder: 55 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 55 No regulatory insufficiencies were cited during the investigation of Complaint #79904-C or Complaint #80576-C. The following regulatory insufficiency was cited during the investigation of Complaint #80299-C.	A 000		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provided care, treatment, and services which were adequate and appropriate for 1 of 4 tenants reviewed (Tenant #1). Findings follow: Review of Tenant #1's file indicated an admission date of 10-5-17. Recertification Reassessment	A 013	See attached Response and Plan of Correction	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 013	Continued From page 1 forms dated 10-8-18 and 12-5-18 revealed he required assistance with mobility, transfers, bathing, grooming, and dressing. He required a wheelchair for mobility and the assistance of one staff for transfers due to inability to bear weight. Further review revealed the Program failed to discuss discharge planning with him. Review of Clinical Notes revealed a 90 day review dated 10-8-18 noting no hospitalizations for the past 90 days. He required a wheelchair for mobility due to spinal nerve damage and continued to remain appropriate for an assisted living. Further review revealed a 90 day review dated 12-5-18 noted progressive weakness with several falls and 911 was used to assist him off of the floor. He was encouraged not to cancel physical therapy due to major concerns of increased weakness. No documentation of discharge planning was provided. A Clinical Note dated 12-7-18 indicated he was taken to the emergency room (ER) after a fall and the Program's nurse "advised the ER nurse that he had become so weak and unable to care for himself that he cannot return to the Program until he returns to his prior functional status." During an interview on 1-2-19 at 3:20 p.m. the Home Health Clinical Manager stated Tenant #1 had fallen and required Emergency Medical Service to assist him off of the floor on 12-7-18. She stated he had to go to the ER due to more than one fall in a short time period. She stated she told the ER staff he could not return due to exceeding level of care. She confirmed that she had not provided appropriate education to Tenant #1 regarding possible discharge if his weakness continued to increase and when he refused physical therapy.	A 013		

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A 013	Continued From page 2 During an interview on 1-2-19 at 3:20 p.m. the Program Administrator stated she tried to visit Tenant #1 in the ER to serve him Notice of Need for Post-Transfer Assessment. She made two attempts to contact Tenant #1, then just left the document on a side table. She failed to obtain a signature from him as he was sleeping. She stated she assumed he received the document since it was left in his room. During an interview on 1-2-19 at 3:20 p.m. the Home Health Registered Nurse Administrator confirmed the Home Health Clinical Manager informed the ER that Tenant #1 could not return due to increased weakness and would need extra supervision to ensure his safety. She stated an assessment was not completed after the family informed the Program they were going to move Tenant #1 closer to them. She confirmed no education was provided to him when he refused physical therapy which could lead to exceeding level of care and possible discharge. She said she could have completed a managed risk agreement but did not think about that at the time he refused physical therapy. She was going to discuss a managed risk agreement with him on 12-9-18 but the hospital admitted him so she didn't do anything at that time. She confirmed Tenant #1 moved to another facility on 12-13-18 and would be discharged from the Program on 1-31-19. She stated in retrospect they should have allowed him to return to the Program and then proceeded with discharge planning if he exceeded level of care.	A 013		

The Rose of East Des Moines, L.P.
By: EverGreen Real Estate Development Corp., Gen. Ptr.
By: _____, President
Gregory A. McClenahan

1-18-2019

1/30/19

Response to Statement of Deficiencies - Plan of Correction

Complaint #80299-C

481-67.3(2) Tenant Rights – to receive care, treatment and services which are adequate and appropriate.

Plan of Correction: Staff will be oriented and trained regarding how to better address progressive deterioration of a client's condition relative to exceedance of level of care parameters and associated consequences for potential discharge. Staff will be oriented to the importance of education of a client when the potential for exceedance of level of care criteria is implicated. Level of care discussions may occur at any point when observations of deterioration occur, which observations may be upon 60/90 day reviews, significant worsening or annual review or other points when deterioration is observed or noted. The consequence of program discharge relative to exceedance of level of care and communication of those consequences to a client will be emphasized as part of staff orientation and training.

Level of care and involuntary tenant discharges are among the more difficult patient care issues in the Rose Communities. Frequently, a level of care exceedance issue arises in connection with an acute episode that results in an abrupt change in a client's condition. In those instances, the service provider may not have had the opportunity to engage in an educational discussion with the client regarding looming level of care exceedances and discharge consequences. Most often, the same acute episode results in an interim transfer to another facility for treatment. Typically, an acute episode generates symptoms that make it obvious that until the acute episode and associated symptoms abate, the client exceeds level of care and would not satisfy occupancy criteria unless and until the client's condition and symptoms change. That type of scenario happens frequently. The Rose has adopted an interim/conditional discharge notice for such instances, which informs the client that they no longer satisfy level of care parameters and will no longer be able to reside at the Rose unless their condition improves and symptoms abate. We feel the form provides flexibility for the client – they can either make an immediate decision to vacate their apartment or they can hold their apartment during their recuperative period and return to the Rose if their return-to-facility assessment verifies their suitability for continued occupancy.

The Rose developed what is called a "Notice of Need for Post Transfer Assessment: Tenant's Rights of Appeal and Rights of Lease Termination." This form has become a frequently used form for the type of situation where a resident leaves the facility abruptly and it is clear that absent improvement, the resident is not appropriate for return. We make an effort to provide this form at an early point in the absence, so the client understands the inability of the service provider to readmit the client and the facility to allow a return, while at the same time, it gives the client the opportunity to appeal the determination of unsuitability or to make other plans if they feel that improvement is unlikely.

The Notice of Need for Post Transfer Assessment was used in the instance involved in this POC. While we agree that the client's deteriorating condition and the potential discharge consequences could have been addressed at an earlier point with the client, we also maintain that use of the Notice of Need for Post Transfer Assessment form was properly used while the client was at the Hospital ER. The Rose service provider had no ability to meet the needs of the client and it was appropriate to advise the hospital ER and the client of that position. Returning the client to the Rose would have placed the

1/28/19

client's well-being in jeopardy. This was communicated to the hospital ER and eventually the client was admitted by the hospital.

The training and education provided to Open Arms staff will emphasize the integration of early education and opportunities for use of managed risk agreements, when such opportunities are present. The Notice of Need for Post Transfer Assessment will remain an important element in how the Rose manages level of care exceedances and presentation of discharge options to residents who may be temporarily out of the facility. We will emphasize in the training early recognition of level of care concerns so that every effort is made to alert clients to discharge consequences that accompany deterioration of condition and exceedance of level of care, whether the exceedance be gradual or abrupt.

As we indicated, circumstances of level of care exceedances and discharge consequences are among the most difficult situations for staff and client and client families. We will proceed to emphasize with staff the importance of educating and sensitizing clients and client families to the situations where level of care changes can result in abrupt changes in residency status and qualifications.

The training will occur by February 1st. In order to avoid recurrence, 10% of Rose resident charts, or five, whichever is greater, will be audited every 30 days for a period of three months for level of care concerns and implementation of client education and use of managed risk agreements, when appropriate. Increased emphasis will be placed on the role of consensus-based, managed risk agreements in the continuum of means of addressing level of care concerns.