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
	S0223	A. BUILDING: _____ B. WING _____	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF DES MOINES	1330 19TH STREET DES MOINES, IA 50314

(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: 36 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 36 No regulatory insufficiences were cited during the investigation of Complaints #90187-C, #93313-C or the onsite infrction control survey. The following regulatory insufficiencies were cited during the investigation of Complaint #90119-C and #91593-C.	A 000		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to ensure service plans indicated identified needs and preferences for assistance for 2 of 4 tenants reviewed (Tenant #2 and Tenant #3). Findings follow: 1. During a tour of Tenant #2's apartment on	A 089	Plan of Correction is attached — 12/16/20	

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

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
	S0223	A. BUILDING: _____ B. WING _____	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF DES MOINES	1330 19TH STREET DES MOINES, IA 50314

(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 089	Continued From page 1 10-06-2020 a strong odor of urine was present. Further observations revealed incontinence pads on the furniture. Review of Tenant #2's file on 10-7-2020 revealed Clinical Notes documenting the following: - A note dated 5-4-2020 documented he had bowel/bladder incontinence. - A note dated 6-29-2020 documented ongoing urinary incontinence and education on proper hygiene. - A note dated 8-31-2020 documented ongoing incontinence and a goal of incontinence management. On 10-7-2020 at 11:52. a.m. Staff A confirmed Tenant #2's apartment had a strong noticeable odor of urine for several months. She stated he wore incontinence briefs which he often wet. On 10-8-2020 at 12:58 p.m. Staff B confirmed Tenant #2's apartment had a strong noticeable odor of urine for several months. She stated he left containers of urine in the apartment and urinated in his briefs. The tenant's service plan dated 9-17-2020 revealed he required no assistance with toileting. On 10-7-2020 at 12:30 p.m. the Registered Nurse confirmed she failed to update Tenant #2's service plan to reflect the need to manage incontinence. 2. Review of Tenant #3's service plan dated 11-11-2019 revealed she received assistance with bathing from a home health agency. On 10-7-2020 the Registered Nurse stated the tenant stopped receiving bathing services after	A 089		

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
	S0223	A. BUILDING: _____ B. WING _____	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF DES MOINES	1330 19TH STREET DES MOINES, IA 50314

(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 089	Continued From page 2 she lost her Medicaid benefit on 3-4-2020 and confirmed she failed to update Tenant #3's service plan. On 10-7-2020 at 12:30 p.m. the Registered Nurse confirmed she failed to update tenant's service plans to reflect identified needs.	A 089		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Program failed to maintain a clean and sanitary building for 2 of 4 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. During a tour of Tenant #1's apartment on 10-06-2020 a strong odor of cat urine was present. On 10-7-2020 at 11:52. a.m. Staff A confirmed Tenant #1 owned a cat that frequently urinated and defecated on the carpet for several months. On 10-8-2020 at 12:58 p.m. Staff B confirmed Tenant #1 owned a cat that frequently urinated and defecated on the carpet for several months.	A 154		

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
	S0223	A. BUILDING: _____ B. WING _____	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF DES MOINES	1330 19TH STREET DES MOINES, IA 50314

(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 154	Continued From page 3 On 10-7-2020 at 12:30 p.m. the Registered Nurse confirmed these findings and stated Tenant #1 found a new home for the cat. 2. During a tour of Tenant #2's apartment on 10-06-2020 a strong odor of urine was present. Further observations revealed incontinence pads on the furniture. Record review on 10-7-2020 of Tenant #2's Clinical Notes dated 5-4-2020, 6-29-2020, and 8-31-2020 revealed ongoing issues of urinary incontinence. On 10-7-2020 at 11:52. a.m. Staff A confirmed Tenant #2's apartment had a strong noticeable odor of urine for several months. She stated he wore incontinence briefs and often wet them. On 10-8-2020 at 12:58 p.m. Staff B confirmed Tenant #2's apartment had a strong noticeable odor of urine for several months. She stated he left containers of urine in the apartment and urinated in his briefs. On 10-7-2020 at 12:30 p.m. the Registered Nurse confirmed these findings and stated she would contact his physician for an Occupational Therapy referral for incontinence management.	A 154		

PLAN OF CORRECTION FOR STATEMENT OF DEFICIENCIES
COMPLAINT 90119-C – SUBSTANTIATED
COMPLAINT 91593-C – SUBSTANTIATED

December 7, 2020

12/22/20

Facility Name: The Rose of Des Moines, L.P.
Street Address, City, ZIP: 1331 Idaho Street, Des Moines, IA 50316
Facility Cert Number: S0223
Exit Date: 10/08/2020

481 IAC 69.26 Service Plans (4) The service plan shall be individualized and shall indicate, at a minimum:
a. The tenant's identified needs and preferences for assistance.
Completion Date: 12/2/2020
Narrative: The service plans referenced in the Statement of Deficiencies have been updated to reflect current circumstances. An in service will be conducted with RNs regarding ALF regulations for service plans, nurse reviews and service plan updates, with specific reference to 481 IAC 26 and 27. RNs will be reminded that a Rose service plan should be developed upon move in and updated annually or whenever a change is needed, e.g. upon significant change in condition noted upon RN review. RN reviews should occur for tenants not receiving services upon observed significant change or annually. RN reviews should occur for tenants receiving services upon observed significant change or every 90 days. There will be specific reference to the need to monitor level of care parameters, such as uncontrolled incontinence and to refer clients for supportive treatment, if appropriate.

The two clients referenced in the Statement of Deficiencies have enrolled in an incontinence management program and their progress is being monitored. Service plans have been updated in that regard.

Recurrence will be avoided by monitoring Rose service plans and noting which are subject to annual review and which are subject to the 90-day review. On March 1, 2021, the Open Arms Administrator will audit two service plans from each group (annual and 90-day) for compliance with timely review and updates, if updates are appropriate for the resident's circumstances.

481 IAC 69.35 Structural Requirements (1) General Requirements b. The buildings and grounds shall be well-maintained, clean, safe and sanitary
Completion Date: 12/2/2020
Narrative: The two apartments referenced in the Statement of Deficiencies have been cleaned (carpets) and the soiled furniture items have been removed. The cat has been removed. Both residents have been enrolled in an Incontinence Management program and are progressing. Homemaking has increased to assist with maintaining cleanliness. The odors are significantly improved. Staff have been advised of the importance to monitor similar situations and to report to management for remedial and corrective actions.

Recurrence will be avoided through emphasizing in staff meetings the level of care parameters regarding uncontrolled/unmanageable incontinence and remedial and corrective options that exist to manage such situations.

Gregory A. McClenahan, President of Gen. Ptr.

12-7-2020
Dated

12/16/20