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 03/09/2022

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 disorders: 35 Number of tenants with cognitive disorders: 0 Total: 35 The following regulatory insufficiency was cited during the investigation of complaint # 97857	A 000		
A 160	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 provide adequate and appropriate care for 1 of 1 tenants reviewed (Tenant #1). Findings follow. Review of Tenant #1's file revealed a medication status report dated 10/22/20 indicating the tenant received Lyrica 100 milligram (mg) twice a day. The start date of the order was 11/25/19. A clinical note dated 5/21/21 noted a medication error written by RN (Registered Nurse) A. (RN A was no longer employed at the program). The note stated on 3/17/21 Tenant #1's podiatrist sent	A 160	See attached Plan of Correction for Statement of Deficiencies.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

The Rose of Des Moines, L.P.
By: EverGreen Real Estate Development Corporation, Gen. Ptr.
By: _____, President
Gregory A. McClendon
03-21-2022

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 160	Continued From page 1 an escript for pregabalin (Lyrica) 300 mg daily to the pharmacy. The pharmacy filled the Lyrica order on 4/2/21 and 4/28/21. The program never received an order from the podiatrist to update the medication list and did not notice the changed prescription on the bottles when filling the tenant's medication planner. The tenant had run out of Lyrica at one point, so he had received between 0 mg and 600 mg per day (300 mg twice a day) of Lyrica since the higher dose was first placed in the medication planner on 4/9/21. The tenant's doctor's office was notified. No order from the podiatrist for pregabalin (Lyrica) 300 mg daily could be located in the tenant's file, nor was there an order to discontinue the Lyrica 100 mg twice a day prescribed by his primary care provider on 11/25/19. Tenant #1's service plan indicated as of 11/25/19 the Open Arms (home health agency) nurse would complete med set-up weekly. Staff would assist with medication reminders. Per an email from the RN Clinical Manager dated 2/17/22, the program did not administer medications, therefore no medication administration records existed. Interviews on 1/4/22 and 1/5/22 with RN B revealed Tenant #1 was taking Lyrica 100 mg twice a day when he was admitted to the program. She noted the program was initially not aware that Tenant #1's Lyrica had been changed to 300 mg once a day. The program had not received the prescription notice from the tenant's podiatrist and she did not know why the podiatrist prescribed the Lyrica. She added the only indication of the changed dosage was the 300 mg once a day label on the medication container. RN B stated RN A was responsible for filling Tenant	A 160		

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A 160	Continued From page 2 #1's medication planner. She believed RN A assumed, without looking at the medication container, the tenant was still receiving Lyrica 100 mg twice a day. As a result, the tenant received two doses of Lyrica 300 mg twice a day after the change was made by the podiatrist. RN B also indicated Tenant #1 had exhibited some physical decline especially when restrictions were put in place due to Covid. Interview with RN C on 3/9/22 revealed she did not work at the program when this medication occurred. When questioned about the process for filling med minders she stated the pharmacy typically delivered medications directly to tenants on Friday evenings in the dining room. Tenants then took their meds to their apartments. If med minders needed to be filled the RN went to the tenant's apartment with the status list (list of medications), checked the medication containers to make sure they matched with the status lists, then filled the med minders for the week. Generally speaking, if there was a change to a medication the tenant, or tenant's family, let the program or home health agency know. When that occurred, the RN updated the status sheet. If the label on a med container did not match the status sheet and the tenant or family had not informed the program of a change, the RN would contact the physician for clarification. A communication note dated 5/21/21 between Tenant #1's Family Clinic and Tenant #1's physician stated RN A was organizing Tenant #1's medications and realized the tenant had two different prescriptions for Lyrica. The communication stated, "She is not sure what dosage that the patient has been getting from 4/2/21 to now (5/21/21)." The communication noted RN A was wondering if the medication error	A 160		

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A 160	Continued From page 3 could be why the tenant was having troubles. According to program chart/clinical notes Tenant #1 had reported falls and an unsteady gate on 4/9/21, 4/13/21 and 4/15/21. On 4/15/21 Tenant, #1 was found in front of his toilet unable to stand. The tenant was sent via ambulance to the emergency room (ER) where he was diagnosed with hyperlipidemia associated with diabetes, kidney disease, traumatic rhabdomyolysis and paroxysmal atrial fibrillation. He was subsequently admitted to the hospital. The hospital records indicated he was admitted for further evaluation of weakness, dizziness and falls. He was found to have rhabdomyolysis with a total CK of 1,134. His total CK improved with aggressive volume replacement. Lisinopril, Requip and Eliquis were held at admission and generalized weakness and renal function improved. He was discharged back to the program on 4/19/21. The discharge medication list included pregabalin (Lyrica) 100mg twice a day. On 5/25/21 Tenant #1's Lyrica orders were changed to 100 mg two times a day. On 2/21/22 Tenant #1's physician noted, in a message from his office, that while it would be uncommon for the Lyrica to cause rhabdomyolysis, it could be possible. When interviewed on 2/21/22 at 10:54 am, a Medicap pharmacist indicated she could not be sure if the Lyrica dosage caused the rhabdomyolysis. She added rhabdomyolysis could be a side effect of the Lyrica received by the tenant.	A 160		

PLAN OF CORRECTION FOR STATEMENT OF DEFICIENCIES
INVESTIGATION # 97857– SUBSTANTIATED

March 17, 2022

Facility Name: The Rose of Des Moines, L.P.
Street Address, City, ZIP: 1330 – 19th Street, Des Moines, IA 50314
Facility Cert Number: S0223
Exit Date: 03/09/2022

481 IAC 67.3 (2) Tenant Rights All tenants have the following rights: (2) To receive care, treatment and serviced which are adequate and appropriate.
Completion Date: 04/04/2022
Narrative: The Medication Administration policy has been amended to emphasize the importance of reconciling prescription bottle labels with the current medication list. Also, the policy was amended to confirm the patient's responsibility to alert the service provider to any changes in medications or dosage levels. An in service will be conducted with RNs/LPNs in order to review and reenforce the proper practices for administering medications per the Rose Medication Administration policy. The medication error was limited to an individual oversight and is not deemed reflective of a systemic deficiency. The amended Medication Administration policy is attached in a redlined format and accepted format.

Recurrence will be avoided by monitoring the practices employed by RNs/LPNs when they set up patient medication boxes. Once in the next 90 days, a med setup process will be observed by a supervisor for each RN/LPN who engages in med setups. Any deficiency will be noted and will warrant a further audit.

Gregory A. McClenahan, President of Gen. Ptr.

03-21-2022
Dated