IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

June 19, 2012

Ms. Christine Vasquez, Administrator
Walden Point
1200 4th Street
Des Moines, IA 50314

RE: Final Recertification Monitoring Evaluation Report – Walden Point, Des Moines, IA

Dear Ms. Vasquez:

Enclosed is the **Final 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 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 **S0240** with effective dates of **July 27, 2012** through **July 26, 2014**.

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 Recertification Monitoring Evaluation Report

Assisted Living Program:

Christine Vasquez, Administrator
Walden Point
1200 4th St.
Des Moines, Iowa 50314

Date of Monitoring Visit:

May 8, 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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	61
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	61
TOTAL census of Assisted Living Program	61

Tenant/Family Satisfaction Results – A community meeting was held with 26 tenants in attendance. The tenants reported general satisfaction with the program. They reported respectful staff interaction and timely response to calls made using emergency pendants. The tenants reported the food served by the program was palatable and the provision of scheduled activities plentiful. They reported the program's environment to be clean and safe, acknowledging they would recommend it to others.

Program History – The program had no regulatory insufficiencies this certification period.

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

A. Medications

Monitoring Observation:

On 5-8-12, the monitor accompanied Staff #1, universal worker (UW) and Staff #2, UW, during medication administration. Staff #2 entered Tenant #7's apartment at approximately 8:00 a.m. Staff #2 removed a prefilled medication planner from a locked cupboard and poured the medications into a medication cup. Staff #2 was prepared to hand the medication cup to Tenant #7 when the monitor asked her how she was sure all the medications Tenant #7 was to receive were in the cup. Staff #2 indicated the registered nurses (RNs) set up each tenants' medications in a planner every two weeks. The universal workers give each tenant his/her medications and document the medications as given. The monitor counted the medications in the medication cup prior to Staff #2 giving the cup to Tenant #7. The monitor noted six pills in the cup. The monitor added up the pills Tenant #7 was to receive at 8:00 a.m., noting Tenant #7 was to receive seven pills. The monitor reviewed all other prefilled morning slots of the medication planner, noting six pills in each remaining slot. The monitor stopped Staff #2 from administering the medications.

Staff #2 called the Clinical Supervisor who immediately came to Tenant #7's apartment. The Clinical Supervisor reported she had filled Tenant #7's medication planner on 5-1-12. She observed the medications in the cup and in all of the other morning slots of the medication planner, noting Tenant #7's Amlodipine to be missing from the planner and cup. The Clinical Supervisor reported Tenant #7 had not had enough Amlodipine on-hand to fill the second week's medication planner. The Supervisor reported she requested a refill of the Amlodipine on 5-1-12 and had not yet returned to Tenant #7's apartment to add the medication to the second week's planner. Tenant #7 reported the medications had been delivered on Friday 5-4-12. The Clinical Supervisor located the newly filled Amlodipine bottle in Tenant #7's locked cabinet.

The monitor reviewed the skilled nurse visit note completed by the Clinical Supervisor on 5-1-12. The note indicated the Clinical Supervisor filled the medication planner for a two week period and left a message with Tenant #7's family member to order more Amlodipine. The note lacked documentation indicating the Clinical Supervisor had not been able to add all of Tenant #7's ordered medications into both medication planners on 5-1-12. Tenant #7's clinical record contained a note, written by the Clinical Supervisor on 5-8-12 at 8:30 a.m., documenting Tenant #7 had been out of Amlodipine on 5-1-12 for the second medication planner which was to begin being used on 5-8-12; therefore, the Clinical Supervisor had been unable to add the Amlodipine to the preset medications as ordered.

Staff #1 entered Tenant #8's apartment at approximately 8:15 a.m. Staff #1 removed a prefilled medication planner from a locked cupboard and poured the medications into a medication cup. Staff #1 was prepared to hand the medication cup to Tenant #8 when the monitor asked her how she was sure all the medications Tenant #8 was to receive were in the cup. Staff #1 indicated the RNs set up each tenants' medications in a planner every two weeks. The universal workers give each tenant his/her medications and document the medications as given. The monitor counted the medications in the medication cup prior to Staff #1 giving the cup to Tenant #8. The monitor noted 11 pills in the cup. The monitor added up the pills Tenant #8 was to receive at 8:00 a.m., noting Tenant #8 was to receive 13 pills. The monitor reviewed all other prefilled morning slots of the medication planner, noting 12 pills in each remaining slot. The monitor told Staff #1 there were only 11 pills in the cup. Staff #1 stated "Okay" and handed the cup to Tenant #8. Tenant #8 emptied the medication cup into his/her mouth before the monitor could stop Tenant #8 from doing so. The monitor was not clear on which medications were missing from the cup.

Staff #1 called Staff #8, RN, to report the medication error. Staff #8 reported when she prefilled Tenant #8's medication planners on 5-1-12 Tenant #8 had not had enough of several medications to fill both planners. Staff #8 indicated she had added all of the medications to the second planner sometime throughout the previous week; however, she had not yet added Tenant #8's Iron pill. Staff #8 indicated when she arrived at the program she would take care of the error.

The monitor reviewed the skilled nurse visit note completed by Staff #8 on 5-1-12. The note indicated the Clinical Supervisor filled the medication planner for a two week period, noting she did not have enough Calcitriol, Glipizide, Paroxetine, Iron and Allopurinol to fill both medication planners as ordered. Documentation indicated Staff #8 sent a request for all five medications to the pharmacy on 5-1-12 with a plan to return

to add the medications to the planner as soon as the medications were delivered. During interview, Staff #8 indicated she believed another nurse had filled Tenant #8's medication planners two weeks prior to 5-1-12. Staff #8 believed that nurse had most likely forgotten to order the missing medications found on 5-1-12 when noting there would not be enough medications to fill both planners at the next visit. Staff #8 kept notes on a piece of notebook paper in her office, indicating when each medication arrived and was added into Tenant #8's medication planner. The note indicated she had not yet added the Iron to Tenant #8's second medication planner.

Tenant #7 and Tenant #8's medication planners and not been set up to correctly reflect physician's orders prior to Staff #1 and Staff #2 giving the medications out of the planner. The program's system did not require the universal workers to verify the planners had the correct medications in each slot prior to giving the medications; therefore, there would be no way to assure each tenant received the correct medications as ordered by the physician.

The monitor reviewed the program's medication error reports for the previous three month period noting the following:

Tenant #	Medication	Physician Order	Error
Tenant #6	Metformin	1000 milligrams(mg) twice daily	Using 500 mg tablets to finish bottle. Needed to give two 500 mg tablets to equal each dose. Pharmacy delivered 1000 mg tablets after bottle of 500 mg tablets had been used. On 5-1-12 nurse found medication planner set up with two 1000 mg tablets twice daily in remaining slots of second planner. Appeared Tenant received twice the dosage ordered for an unknown number of days.
Tenant #9	Coumadin	2.5 mg daily	On 3-28-12 Tenant reported to nurse had not had Coumadin for previous week and none set up in second planner. Nurse verified Coumadin had not been placed in medication planners when set up previous week.
Tenant #10	Gabapentin	100 mg three times daily	Orders in chart say 100 mg twice daily. Called pharmacy. Order was increased to three times daily on 12-12-11. Had only been getting twice daily from 12-12-11 to 2-24-12.

Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)a.)

B. Evaluation of Tenant

Monitoring Observation: Tenant #2, a 69 year old, was admitted to the program on 4-23-11 with diagnoses of: Diabetes, Hypotension and Depression. Tenant #2 scored a 1 on the March 2012 Global Deterioration Scale (GDS), which indicated no cognitive decline. Tenant #2's clinical record contained documentation of an initial evaluation of Tenant #2's health, functional and cognitive status on 3-17-11. The clinical record contained documentation of the RN evaluation of the health, functional and cognitive status on 6-24-11. The RN did not complete an evaluation within 30 days of Tenant #2's occupancy date.

Tenant #4, an 82 year old, was admitted to the program on 5-5-08 with a diagnosis of orthostatic hypotension. Tenant #4 scored a 1 on the March 2012 GDS, which indicated no cognitive decline. Tenant #4's clinical record contained documentation of an evaluation of Tenant #4's cognitive status on 10-11-10. The clinical record contained documentation of the next cognitive evaluation on 12-16-11. The RN did not complete a cognitive evaluation at least annually for Tenant #4.

Tenant #5, a 90 year old, was admitted to the program on 11-24-10 with diagnoses of: Hypertension, Chronic Urinary Tract Infections, Osteoporosis, Anxiety and Depression. Tenant #5 scored a 1 on the 3-23-12 GDS, which indicated no cognitive decline. Tenant #5's clinical record indicated Tenant #5 fell on 12-4-11, fracturing his/her femur. Tenant #5 was hospitalized from 12-4-11 through 12-8-11, at which time Tenant #5 was transferred to a skilled nursing facility to rehabilitate. Tenant #5 returned to the program on 3-23-12. The RN assessed Tenant #5 to be weaker than he/she had previously been, requiring him/her to have physical assistance with transfers. The RN completed an evaluation of Tenant #5's health, functional and cognitive status on 3-23-12 and initiated physical and occupational therapy services for Tenant #5.

Occupational therapy provided services to Tenant #5 through 4-5-12, at which time the therapist determined Tenant #5 could complete all transfers independently. Tenant #5's clinical record lacked an evaluation of health, functional and cognitive status following Tenant #5's significant improvement in transfer abilities.

The RN did not complete evaluations within 30 days of occupancy, with significant change and at least annually for Tenants #2, #4 and #5.

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))

C. Food Service

Monitoring Observation: The program maintained documentation of food safety and sanitation training on 12-5-11. All program staff members who assist with serving of meals to tenants attended the training. The training was taught by the assistant store manager of the local Hy-Vee , the company that prepares all meals for the program. The program was unable to present documentation of the assistant store manager's certification from a state approved food protection program. The program did not have any other employees who had documentation of certification from a state approved food protection program.

Regulatory Insufficiency: A minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by successfully completing a course meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code Chapter 137F. (IAC r. 481-69.28(5)a.(3))

D. Staffing

Monitoring Observation: Upon initiation of the monitoring visit, the program identified the program's current Clinical Supervisor as the delegating registered nurse. The Clinical Supervisor took the position of the program's delegating nurse in January 2010.

Staff #1, UW, had a hire date of 8-3-11. Staff #1's personnel file contained documentation of nurse delegation for personal care tasks and medication administration of oral medications, dated as completed by Staff #6, RN, on 9-5-11. Staff #6 is a trainer for the home health agency that employs Staff #1. The personnel file lacked any documentation of nurse delegation for Staff #1 by the Clinical Supervisor/Delegating Nurse.

Staff #2, UW, had a hire date of 8-16-04. Staff #2's personnel file contained documentation of nurse delegation for personal care tasks and medication administration of oral medications, dated as completed by Staff #7, RN, on 12-14-10. Staff #7 was the program's previous delegating nurse. The personnel file lacked any documentation of nurse delegation for Staff #2 by the Clinical Supervisor/Delegating Nurse.

Staff #4, UW, had a hire date of 1-17-11. Staff #4's personnel file contained documentation of nurse delegation for personal care tasks and medication administration of oral medications, dated as completed by Staff #7, RN, on 1-18-11. Staff #7 was the program's previous delegating nurse. The personnel file lacked any documentation of nurse delegation for Staff #4 by the Clinical Supervisor/Delegating Nurse.

Staff #5, UW, had a hire date of 11-11-11. Staff #5's personnel file contained documentation of nurse delegation for personal care tasks and medication administration of oral medications, dated as completed by Staff #6, RN, on 11-16-11. Staff #6 is a trainer for the home health agency that employs Staff #5. The personnel file lacked any documentation of nurse delegation for Staff #5 by the Clinical Supervisor/Delegating Nurse.

The current program delegating nurse had not yet delegated Staff #1, #2, #4 and #5 in personal care tasks and medication administration despite being in the delegating RN position since January 2010.

Regulatory Insufficiency: A significant number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))