Iowa Department of Inspections and Appeals
Assisted Living Program
Re-certification Monitoring Evaluation Report

Assisted Living Program:

Mary Montgomery, RN, Director
The Homestead
2501 West State Street
Mason City, IA 50401

Date of Monitoring Visit:

April 26, 2005

Monitor(s):

Stephanie Cummins, SW, MA

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 25.8(3)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Re-certification Monitoring Evaluation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under this chapter that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site monitoring evaluation was conducted at The Homestead on April 26, 2005. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP) –

Current number of tenants without cognitive disorder:	20
Current number of tenants with cognitive disorder:	7
Total Population:	27

Dementia Specific Program (DSP) – Not applicable.

Tenant/Family Satisfaction Results – A community meeting was held and tenants stated the food was good; however, it could use some improvements. Tenants stated too many soups were served and they were not served as hot as they would like. The tenants and family reported the activity director did a good job offering plenty of different choices of activities to choose from. The tenants and family described the staff as caring and great and the building was always clean and quiet. The tenants stated they would like an automatic door opener for the front door of the building, as it was very heavy.

Complaint History – There were no substantiated complaints during this certification period.

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

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

Monitoring Observation: Four tenant files reviewed indicated the program evaluated tenants cognitive and functional status prior to occupancy; however, three out of four files indicated the tenant's physician completed the health assessment after occupancy. Interviews with administrative staff and review of tenant files indicated the program evaluated the tenant's health and functional status within 30 days of occupancy, but did not evaluate tenant's cognitive status. Tenant #1 was hospitalized from 2-8-05 to 2-12-05 for behaviors; however, a formal assessment using cognitive, functional and health tool was not completed prior to the tenant returning to the program. According to the director, before a tenant is readmitted to the program the Registered Nurse (RN) speaks with the discharge planner, reviews physician orders, medications, review of systems, and has a one-on- one visit with the tenant discussing issues relevant to the tenant's ability to function at the program and the ability of the program to provide the needed safety and services.

- Regulatory Insufficiency: The program did not evaluate tenant's functional, cognitive and health status prior to occupancy, within 30 days of occupancy and as needed with change in condition.

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

Monitoring Observation: Four out of four tenant files indicated the program developed the service plan within 30 days of occupancy, but not prior to occupancy. The program did not update the service plan after Tenant #1 was hospitalized. The last update on the service plan was dated 12-04-04. The tenant, RN, Licensed Registered Nurse (LPN) and another staff member originally signed the service plan on 12-5-02.

- Regulatory Insufficiency: The program did not develop a preliminary service plan for all tenants prior to taking occupancy.

- Regulatory Insufficiency: The program did not appropriately update and sign service plans as needed with change in condition and annually.

C. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

Monitoring Observation: Review of program files indicated the program completed a review of medications every 90 days and review of health related care activities every 90 days. The LPN noted new physician orders by signing and dating, but not timing the actual order. In the nurse's notes the LPN would record an entry that stated the time and that a new order was received.

- Regulatory Insufficiency: The program LPN did not appropriately document reviews showing the time, date and signature.

D. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Monitoring Observation: Interview with program director and review of employee files indicated an RN delegated medication administration and personal cares to the direct care staff. The program had employees complete a Medication Aide Competency Checklist and the RN observed them passing medications. The program had a Personal Care Readiness Tool form; however, it was not completed for all direct care staff members.

- Regulatory Insufficiency: The program did not have staff appropriately trained.

E. Transportation – When the program provides transportation services directly or under contract with the program, the services shall be provided as required. [321 IAC 25.38]

Monitoring Observation: The program had a six passenger mini van equipped with a fire extinguisher, first aid kit, safety triangles and a cell phone. According to the director employees with a regular State of Iowa Drivers License drove the van.

- Regulatory Insufficiency: The program did not have employees appropriately licensed as required for the vehicle being used for transportation of tenants.

Dated this 3rd day of May, 2005.

The Homestead
Assisted Living Residence

May 13, 2005

Connie Schaffer
Certification Coordinator – Central
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319 0083

Re: Re-certification Monitoring Evaluation Report – Plan of Correction

A. Evaluation of Tenant – The program evaluates each tenant's functional and cognitive abilities and health status and determination of needed services as required.321 IAC 25.23(1) and/or (2).

Regulatory Insufficiency: The program did not evaluate tenant's functional, cognitive and health status prior to occupancy, within 30 days of occupancy and as needed with change in condition.

Plan of Correction:
The file sited for Tenant #1 has been updated. There is now in place a Pre – Admission, 30 days, Re-Admission after hospitalization functional, cognitive and health status form – see enclosed documents.

The tenant's functional, cognitive and health status will be evaluated prior to occupancy, within 30 days of occupancy and as needed with change in condition this is effective immediately.

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. 321 IAC 25.28

Regulatory Insufficiency: The program did not develop a preliminary service plan for all tenants prior to taking occupancy.

Plan of Correction: There is now in place a Pre-admission service plan – see enclosed documents effective immediately.

2501 W. State Street • Mason City, IA 50401 • 641-423-4809 • Fax: 641-423-0441

Regulatory Insufficiency: The program did not appropriately update and sign service plans as needed with change in condition and annually.

Plan of Correction: There is now in place and effective immediately that service plans are updated and signed by tenant or legal representative, RN, Health Services Coordinator, and Personal Care personnel - annually and with any change in condition. See enclosed documents.

C. **Nurse Review** – Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. 321 IAC 25.20

Regulatory Insufficiency: The program LPN did not appropriately document reviews showing the time, date and signature.

Plan of Correction: There will be a place on the physician order form and Reviews, to be noted by being signed, dated and timed, by a licensed nurse. This is effective immediately.

D. **Staffing** – The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identify needs of the tenant. 321 IAC 25.33
Regulatory Insufficiency: The program did not have staff appropriately trained.

Plan of Correction: The RN will do a personal care review according to hire date on each staff member involved in personal care of tenants. This review will be completed by May 25, 2005 and done yearly, and filed in each employee's personnel file.

Plan of Correction: Medication Aide Competency Checklist will be filed with Staff personnel file, which also contains the certificate of Medication Aide or Medication Manager certificate. The date this correction will be completed is May 25, 2005.

E. **Transportation** – When the program provides transportation services directly or under contract with the program, the services shall be provided as required. 321 IAC 25.33

Regulatory Insufficiency: The program did not have employees appropriately licensed as required for the vehicle being used for transportation of tenants.

Plan of Correction: The Transportation policy will include that only staff members with a D3 chauffeur's license will transport tenants in the facility van. Effective May 10, 2005. See enclosed copy of staff D3 driver's license.
A copy of their current D3 chauffeur's license will be kept the staff's personnel file. This is effective immediately.

If you have any questions regarding these Plans of Corrections please, please contact me at 641 423-4809.

Sincerely, Shirley A Marrick RN
Sharon Agnitsch LPN HSSC

Sharon Agnitsch, Health Services/Staffing Coordinator, LPN
Mason City Homestead Assisted Living
s.s.

FUNCTIONAL ASSESSMENT

Name:_____ Room#:_____ Date: _____

Rate the resident on a scale of 1 to 5 with 1 being most independent. Total all checked scores and enter that amount on Page 4 of this assessment.

FUNCTION	LEVEL OF FUNCTIONING	COMMENTS
1. BATHING (washing the body)	__ 1. Independent – no assistance required in bathing – uses assistive/adaptive devices (shower stool, handrails, etc.) needs occasional reminding. __ 2. Preparation needed of bath water and or bathing articles (soap, towels, washcloth, etc.); individual can wash self. __ 3. For safety reasons or unsteadiness; may require assistance into/out of the/shower. __ 4. Some assistance needed – individual is able to wash face and hands only. __ 5. Total assistance needed with preparation, helping individual in and out of the tub, complete washing and drying of the body.	
2. HYGIENE (and grooming)	__ 1. Independent – no assistance required – uses assistive/ adaptive devices. __ 2. Minor assistance needed, including reminders to bath, shave, comb hair, clip nails, brush teeth, etc. __ 3. Needs higher degree of assistance, such as preparation of grooming materials, help with dentures, etc. __ 4. Requires limited physical assistance, such as steadying of hands when shaving or combing hair, assistance because of physical impairment, etc. __ 5. Total assistance required in washing, combing hair, clipping nails, brushing teeth, shaving, etc.	
3. Dressing (putting on or removing proper clothing)	__ 1. Independent – no assistance required – uses assistive/ adaptive devices. __ 2. Needs occasional help with zippers, buttons, typing shoe-laces, etc. __ 3. Needs structuring – daily assistance with what to wear as well as zippers and buttons. __ 4. Moderate assistance – puts clothing on or takes clothing off with assistance; needs help with prosthesis. __ 5. Fully dependent – individual can offer no assistance, requires someone to completely dress.	
4. Continence	__ 1. Continent __ 2. Occasionally incontinent but under control with medications and doctor's supervision. __ 3. Minor assistance needed such as reminders and/or assistance to and from bathroom. __ 4. Substantial assistance required – must have a schedule for toileting and be taken to and from the bathroom; Needs assistance in cleaning. __ 5. Incontinent	
5. Mobility (moving from place to place)	__ 1. Totally independent – needs no assistance – uses assistive/ adaptive devices (wheelchair, walker, etc.) __ 2. Independent inside the residence/facility; dependent	

	outside the residence/facility. __ 3. Not always reliable – walks with supervision or ambulation device. __ 4. Always requires guide or assistance due to physical problems or confusion; requires amulation device but can maneuver wheelchair on own. __ 5. Dependent – requires assistance from bed to chair and vise versa; requires wheelchair for mobility but cannot maneuver without assistance.	
6. Medications	__ 1. Takes own medication with proper dosages on schedule; no assistance needed in storage or organizing. __2. Needs medication dosages prepared in advance but can self-administer on a predetermined schedule. __ 3. Needs assistance with storage, preparation, and reminders as to scheduling. __ 4. Requires health care professional to administer prescription medications. __ 5. Requires complete supervision and administration of all medications.	
7. Dietary	__ 1. Totally independent – uses assistive/adaptive devices __ 2. Assistance needed occasionally in opening cartons, jelly packets, cracker wrappers, condiment jars, etc. __ 3. Minor assistance needed in cutting meats, etc; but able to feed self. __ 4. Moderate assistance – untidy, cannot hold cup or utensils; prompting required. __ 5. Dependant – physical assistance required for all facets of eating.	
8. Shopping	__ 1. Individual takes care of own needs __ 2. Minor assistance may be needed with transportation and or carrying bundles. __ 3. Assistance required in deciding and procuring __ 4. Needs assistance with handling money transactions. __ 5. Totally dependent – unable to shop for self.	
9. Housekeeping	__ 1. Keeps apartment clean but needs help with heavy work (lifting or moving furniture or large items.) __ 2. Can perform light housekeeping tasks such as dishwashing, bedmaking, dusting, vacuuming. __ 3. Very light tasks only – cannot maintain acceptable level of cleanliness. __ 4. Cannot maintain orderliness of personal items, clothing or foodstuffs, which may cause a safety or health problem. __5. All tasks must be performed by staff.	
10. Laundry	__ 1. Sends out or does own. __ 2. Needs assistance with loading/unloading laundry machinery. __ 3. Able to do small items only. __ 4. Needs reminders to launder personal clothing and linens, assistance required with dispensing soap and bleach, using equipment, sorting, etc. __5. All tasks must be performed by staff.	
11. Telephone	__ 1. No assistance needed to make outgoing or receive incoming calls – uses assistive/adaptive devices.	

	__ 2. Assistance needed to initiate some calls; able to receive calls. __ 3. Individual only able to dial a few numbers committed to memory. __ 4. Individual only able to answer telephone, cannot initiate calls or remember number sequences. __ 5. Staff must make and receive calls for individual – unable to communicate using the telephone for reasons other than loss of hearing; unable to use the telephone to call for assistance or in an emergency – unable to use assistive devices or adaptive equipment.	
12. Mental Status (orientation, memory, judgement)	__ 1. Oriented in person, place and time. __ 2. Mild impairment – some confusion, difficulty in remembering details in conversation, forgetful, may need some initial guidance. __ 3. Moderate impairment – memory loss, especially of current events – may appear to be functional on surface but detailed conversation reveals problems of withdrawal depression, isolation, etc; strong reminders are required. __ 4. Heavy impairment in all areas thus requiring constant orientation program; unable to remember personal information; confused as to time and place.	
13. Safety	__1. Independent; understands fire protocol, emergency response system. __ 2. Requires reminders to use and wear emergency response pendant. __ 3. Wears pendant at all times – requires reminders to use, provides escort or SBA with fire drills. __ 4. Total dependence of one caregiver to assist with evacuations fire drill – unable to use emergency response pendant.	
12. Activities	__ 1. Independent – no assistance needed. __ 2. Requires encouragement and reminders of events daily __ 3. Physical assistance of one person to escort to events – attends only special programs. __ 4. Dependent on staff to participate in daily and special events; attends only with assistance.	

RATING

Enter the rating from the preceding assessment, if applicable

Add together the checked scores for all 12 functional categories. Using the scale below determine the rating for this assessment

Rating: **Total Score**: 16 – Independent 17-18 Moderately Independent 49-72 Moderately Dependent 73-80 Completely Dependent

- Note: if a score of 4 or 5 was indicated in any two of these categories, resident should be recommended for a higher level of care.

Date of Preceeding Assessment _____ Rating _____

Total Score Of This Assessment _____ Rating _____

Service Plan Team	
Signature / Title	Date/Time
Tenant /Legal Representive	Date

Pre -Admission _____

30 Day _____

Change in Condition (including after hospitalization) _____

Annually _____

Revised 05-11-05

Mental Status Questionnaire

Name – Last_____First_____Middle_____Date_____
Pre-Admission_____
30 day _____
Change in Condition (including after hospitalization)_____
Annually_____

Record interviewee's own words. If there is a question about appropriateness / validity of the answer, give not hints. Repeat questions as often as necessary, but do not rephrase.

1. **What is your name? (One point)**
   Answer:_____

2. **What is the name or address of this building? (One point)**
   Answer:_____

3. **In what city and state is it located? (One point)**
   Answer:_____

4. **What is today's date (day of the week not acceptable)? What month is it? What year is it? (Three points)**
   Answer: _____

5. **How old are you? (If records indicate birthday uncertain, credit if estimate is within two years of age given by family) (One point)**
   Answer: _____

6. **When were you born? (Month, date, year) (One point)**
   Answer:_____

7. **Who is President of the United States? (One point)**
   Answer: _____

8. **Who was President before him? (One point)**
   Answer:_____

9. **What was the last holiday? (One point)**
   Answer: _____

Comments:

_____
_____
_____
_____

Scale:
9-11 points: no or mind impairment
5-8 points: moderately advanced impairment
0-4 points: severe brain dysfunction

Score:_____points

Date/Time of Evaluation_____

Signature/Title_____

The Homestead
Assisted Living Residence

PHYSICIAN APPOINTMENT FORM

Date: _____ Suite #: _____ BD: _____
Resident's Name: _____
Medicare #: _____
Diagnosis: _____
Allergies: _____

Reason for Appointment: _____

Present Status: (Circle One) Good Fair Guarded

Medications – See Attached MAR

Physician's Instructions: _____

Physician Signature: _____

Please return form with resident to The Homestead Assisted Living Facility. Thank you for your cooperation.

_____ _____
Signature/Title Date

Noted: Signature/Title:_____ Date: _____ Time:_____

Nursing Assessment Form

Pre-Admission_____
30 days_____
Change in Condition (including after hospitalization) _____
Annually_____

Name:	**DOA:**	**Sex:**	**Suite**
Physician:	**DOB:**	**Age:**	
Primary Dx: **Secondary Dx:**			
Allergies:			

1. Past Medical History: (Check all that apply)

___ Heart Disease _____
___ Congestive Heart Failure _____
___ Stoke _____
___ Depression _____
___ Diabetes _____
___ Mucular Degeneration _____
___ Substance Abuse _____
___ Other _____

___ Heart Attack _____
___ High Blood Pressure _____
___ Cancer (Type) _____
___ Arthritis _____
___ Joint Replacement (s) _____
___ Cataracts _____
___ Incontinence _____
___ Other _____

2. Do you: (Check all that apply)

___ Wear glasses? _____
___ Have dentures? _____
___ Have hearing aid (s) _____
___ Use a cane? _____

___ Use a walker? _____
___ Use a wheelchair? _____
___ Use Depends/pads? _____
___ Smoke? _____

3. Mental Status: (Check all that apply)

___ Alert ___ Lethargic ___ Forgetful ___ Confused ___ Wanderer

4. Vital Signs:

BP _____/_____ ___ Standing ___ Sitting ___ Lying down

Apical Pulse _____ ___ Regular Rhythm ___ Irregular Rhythm

Radial Pulse _____ ___ Regular Rhythm ___ Irregular Rhythm

Respirations _____ ___ Regular Rhythm ___ Irregular Rhythm

Temperature _____ ___ Oral ___ Axillary ___ Tympanic

Height _____

Weight _____

5. Resiratory Status:

___ Eupnea ___ Dyspnea ___ Shallow Respirations Lung Sounds: _____

6. GU: ___ Voiding without difficulty ___ Hematuria ___ Dysuria ___Catheter Frequency _____ Urgency_____

7. GI: ___ Constipation ___ Diarrhea ___ Blood in Stool

8. Skin Status: ___ Pink ___ Pale ___ Warm ___ Cool

Please list and specify location of any open wounds, skin tears, pressure ulcers, lesions, abrasions, bruising or any impaired skin integrity: ______________________________

____

9. Assess Edema:

____

10. Pain :

___ Location ___ Quality ___ Frequency ___Relief

____

11. Family involvement: ___ Strong ___ Moderate ___ Weak

Date /Time of Evaluation ____________________ **Signature/Title**____________________

Tenant/Applicant ______________________________ **Date:** ___/___/___
Or Legal Representative

Date /Time of Evaluation ____________________ **Signature/Title**____________________

Tenant/Applicant ______________________________ **Date:** ___/___/___
Or Legal Representative

Date /Time of Evaluation ____________________ **Signature/Title**____________________

Tenant/Applicant ______________________________ **Date:** ___/___/___
Or Legal Representative

Date /Time of Evaluation ____________________ **Signature/Title**____________________

Tenant/Applicant ______________________________ **Date:** ___/___/___
Or Legal Representative

Date /Time of Evaluation ____________________ **Signature/Title**____________________

Tenant/Applicant ______________________________ **Date:** ___/___/___
Or Legal Representative

The Homestead
Assisted Living Residence

Pre-Admission_____ **30 Day**_____ Service Plan
Change in Condition (including after hospitalization)_____
Annually_____
Name: _____ Unit/Room #: _____ Care/Service Plan Date: _____ Level: _____

FUNCTION	ACTION PLAN	STAFF OR AGENCY RESPONSIBLE
Bathing Score _____ Expected Outcome		
Hygiene Score _____ Expected Outcome		
Dressing Score _____ Expected Outcome		
Continence Score _____ Expected Outcome		
Mobility Score _____ Expected Outcome		
Mental Status Score _____ Expected Outcome		

* FUNCTION	ACTION PLAN	STAFF OR AGENCY RESPONSIBLE
Medications Score _____ Expected Outcome		
Dietary Score _____ Expected Outcome		
Shopping Score _____ Expected Outcome		
Housekeeping Score _____ Expected Outcome		
Laundry Score _____ Expected Outcome		
Activities Score _____ Expected Outcome		
Safety Score _____ Expected Outcome		
Telephone Score _____ Expected Outcome		

* Note: if a score of 4 or 5 was indicated in any two of these categories, tenant should be recommended for a higher level of care.

		Primrose	Columbine	Sunflower
Ratings:	**16 Level 1**	**$2350.00**	**$2625.00**	**$3050.00**
	17-27 Level 2	**$2600.00**	**$2875.00**	**$3300.00**
	28-40 Level 3	**$2875.00**	**$3150.00**	**$3550.00**
	40+ Level 4	**$3250.00**	**$3500.00**	**$3925.00**

Service Plan Team

Tenant or Legal Representative	Date/Time	Revision Date
RN	Date /Time	Revision Date
Health Service Coordinator	Date /Time	Revision Date
Personal Care Personnel	Date/Time	Revision Date

Name of nurse or agency responsible for the skilled nursing services: _____

Responsible for: (circles appropriate one)

1. Shopping: Staff / Family / Tenant
2. Management of Medical Treatments: Staff / Family / Tenant
3. Money Management: Family / Tenant

Supervised nursing services: _____

_____

_____

Name of nurse responsible for nursing plan: _____

Transportation

Policy

Transportation provided for the tenants for local medical appointments and at the discretion of the director for weekly shopping.

Policy Interpretation and Implementation

1. The vehicle shall be accessible and appropriate to the tenants using it, with consideration for any physical disabilities and impairments.
2. Every tenant who is being transported shall have a seat in the vehicle, except those who remain in their wheelchairs.
3. Wheelchairs shall be secured when the vehicle is in motion.
4. Vehicles will have adequate seat belts for those who are ambulatory and security devices for those in wheelchairs.
5. During loading and unloading of a tenant, the driver shall be in the proximate area of the other tenants in the vehicle.
6. Only staff that has a valid D3 chauffeur's license as required by law can transport tenants. A copy of this license will be kept in the personnel file.
7. Each vehicle shall have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication.