IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

June 9, 2008

Ms. LuAnn Rogge, Administrator
Heartland Care Center
604 East Fenton
Marcus, IA 51035

RE: Recertification Monitoring Evaluation Report, Heartland Care Center, Marcus, IA

Dear Ms. Rogge:

The Department of Inspections and Appeals (DIA) has completed the review of your Plan of Correction (POC) in response to the **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. A copy of the Final report is enclosed.

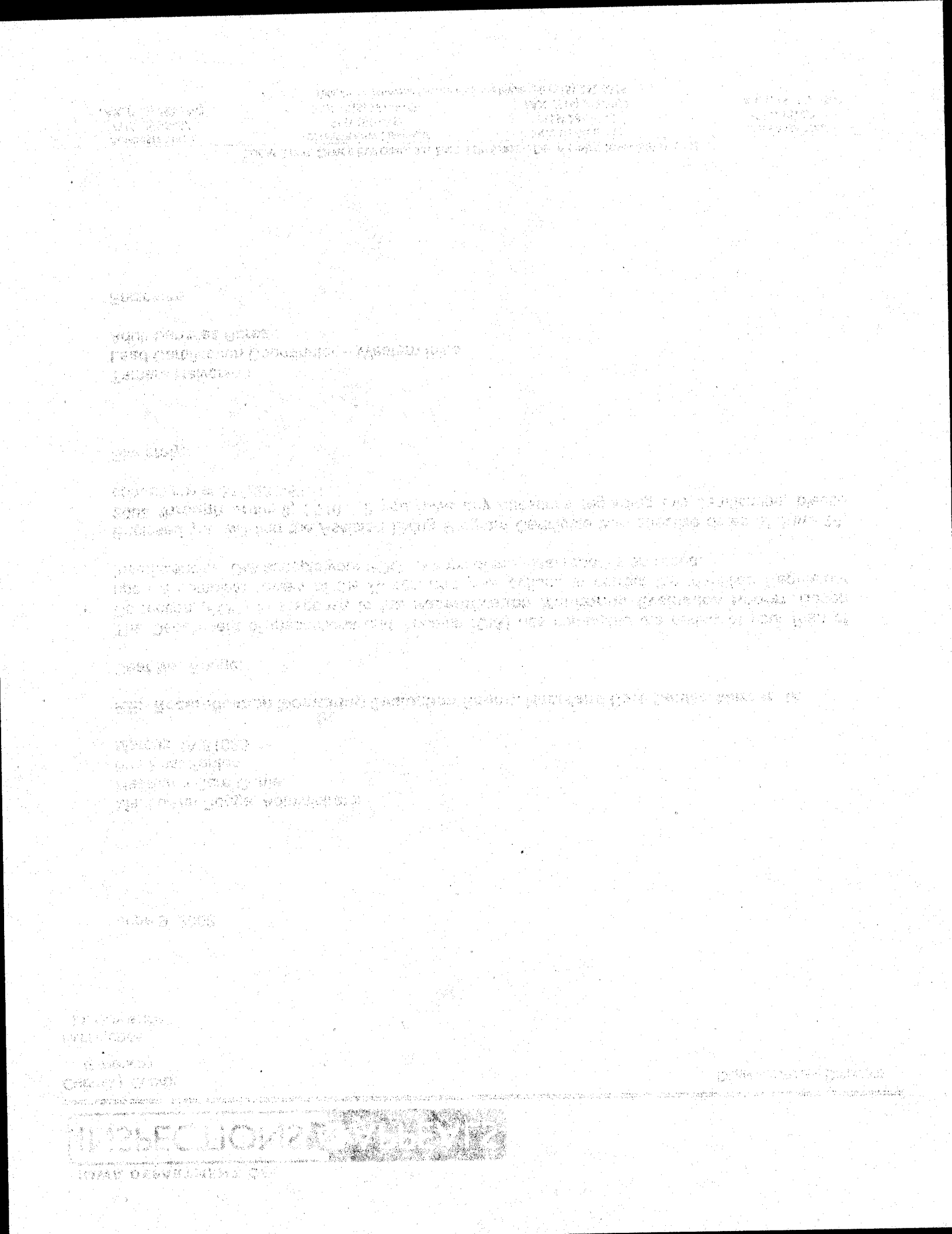
Enclosed you will find the Assisted Living Program Certificate with effective dates of **June 10, 2008 through June 9, 2010**. If you have any questions regarding this certification, please contact me at 515/281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
Lead Certification Coordinator – Western Iowa
Adult Services Bureau

Enclosure



Iowa Department of Inspections and Appeals
Assisted Living Program
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

LuAnn Rogge, Administrator
Heartland Care Center
604 E. Fenton
Marcus, IA 51035

Date of Monitoring Visit:

April 15, 2008

Monitor(s):

Michael Streepy, RN

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 Recertification Monitoring Evaluation Report. Depending on the circumstances, DIA may revisit 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 Heartland Care Center on April 15, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	15
Current number of tenants with cognitive disorder:	1
Total Population:	16

Dementia Specific Program (DSP)* – Not applicable.

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – A community meeting was held with 5 tenants. Tenants stated the environment was very good with excellent housekeeping and laundry services. Tenants characterized staff as wonderful, very helpful and friendly with good response to requests for assistance. Tenants stated the food is okay with substitutes offered and portion sizes being too large. Tenants stated there is a variety of stimulating activities offered. Tenants feel safe in the program, fire drills are held regularly and evacuation routes are understood. Tenants stated services are provided as expected, and they are aware of limitations to eligibility. Tenants make their own decisions with no restrictions. Tenants are satisfied with medical services. Tenants stated general satisfaction with the program and would recommend it to friends and family.

Program History – There were no substantiated complaints 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: Tenant #1, a 100 year old, was admitted 05-10-05 with diagnoses including: Micro Ischemic Cerebral Vascular Accident, Prostate Cancer, Esophageal Stricture, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Orthostatic Hypotension, Asthma, Venous Insufficiency, Osteoporosis and Atrial Fibrillation. The tenant scored a two on the Global Deterioration Scale (GDS) indicating very mild cognitive decline dated 2-18-08. Tenant record review reveals physician communication dated 02-04-08 indicating the tenant had been prescribed Macrodantin and Tetracycline on 01-22-08 for urinary tract infection. Review of nurse's notes of 02-19-08 indicates an order for skin treatment with triple antibiotic ointment to the right hip daily until healed. Review of a New Medication/Change in Medication Sheet dated 02-25-08 reveals the tenant was given an order for Bactrim DS one twice daily for 21 days for urinary tract infection. Review of nurse's notes of 03-10-08 revealed a skin tear, and a physician's order of 03-10-08 directs staff to cleanse the right upper arm with normal saline, apply tegaderm and change every 5 to 7 days until healed. Review of a Wound Evaluation Flow Sheet dated 04-05-08 reveals the tenant with an area on the left hip measuring 3.0 centimeters by 2.5 centimeters. There was no documentation of functional, health or cognitive evaluations following the condition changes.

Tenant #2, a 93 year old, was admitted to the program on 10-20-06 with diagnoses including: Urinary tract infection with Urosepsis, Anemia, Hypothyroid, Hypertension, Glaucoma, Spinal stenosis, History of Detached Retina – Left Eye and History of Cancer – Left Breast. Review of the nurse's notes dated 02-12-08 at 10:30 a.m. reveals the tenant to have a complaint of cold symptoms with chest congestion, stuffy nose and cough. Nurse's notes of 02-12-08 at 4:20 p.m. reveal the tenant with an oxygen saturation of 88% and the placement of oxygen at 3 liters with the tenant's oxygen saturation increasing to 94% but with breath sounds diminished throughout. The ARNP was notified 02-13-08 and an order for chest x-ray along with scheduled labs was received on 02-14-08. The tenant was admitted to the hospital on 02-15-08, with a diagnosis of pneumonia. Tenant returned to the program on 02-22-08, with a new diagnosis of diabetes, an order for Metformin 500 mg twice a day and blood glucose monitoring twice a day. There was no documentation of nurse review before or after the hospitalization. There was no documentation of functional, health or cognitive evaluations following the condition changes.

Tenant #3, a 90 year old, was admitted to the program on 07-25-05 with diagnoses including: Dementia, Anemia, Osteoarthritis, Peripheral Vascular Disease and History of Osteoporosis. The tenant had a score of 3 on the GDS indicating mild cognitive decline. Review of nurse's notes of 10-12-07 indicates changes including an episode of incontinence. Nurse's notes dated 10-15-07 reveals staff finding clothing in the tenant's room soaked in urine and on 10-16-07 housekeeping staff report finding tenant's jewelry in the garbage the past two days. Nurse's notes dated 10-21-07 reveal the tenant complaining of feeling dizzy, lightheaded and seeing spots, and the tenant unable to sit or stand without help. The notes of 10-21-07 indicate a physician's order obtained with medication ordered and family notification.

The record contained no documentation of functional, health or cognitive evaluations following the condition changes.

- Regulatory Insufficiency: The program did not consistently ensure each tenant's functional, health and cognitive status would be evaluated as needed to ensure the tenant's continued eligibility for the program and to determine any modifications to services needed. (25.23(2))

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

Monitoring Observation: Tenant #1, had record documentation of physician communication dated 02-04-08 indicating the tenant had been prescribed Macrodantin and Tetracycline on 01-22-08 for urinary tract infection. Review of nurse's notes of 02-19-08 indicates an order for skin treatment with triple antibiotic ointment to the right hip daily until healed. Review of a New Medication/Change in Medication Sheet dated 02-25-08 reveals the tenant was given an order for Bactrim DS one twice daily for 21 days for urinary tract infection. Review of nurse's notes of 03-10-08 revealed a skin tear, and a physician's order of 03-10-08 directs staff to cleanse the right upper arm with normal saline, apply tegaderm and change every 5 to 7 days until healed. Review of a Wound Evaluation Flow Sheet dated 04-05-08 reveals the tenant with an area on the left hip measuring 3.0 centimeters by 2.5 centimeters. The tenant's service plan was not updated to reflect required treatment.

Tenant #2, had nurse's notes dated 02-12-08 at 10:30 a.m. revealing the tenant to have a complaint of cold symptoms with chest congestion, stuffy nose and cough. Nurse's notes of 02-12-08 at 4:20 p.m. reveal the tenant with an oxygen saturation of 88% and the placement of oxygen at 3 liters with the tenant's oxygen saturation increasing to 94% but with breath sounds diminished throughout. The ARNP was notified 02-13-08 and an order for chest x-ray along with scheduled labs was received on 02-14-08. The tenant was admitted to the hospital on 02-15-08, with a diagnosis of pneumonia. Tenant returned to the program on 02-22-08, with a new diagnosis of diabetes, an order for Metformin 500 mg twice a day and blood glucose monitoring twice a day. The tenant's service plan was not updated to reflect required treatments.

Tenant #3, had nurse's notes of 10-12-07 indicates changes including an episode of incontinence. Nurse's notes dated 10-15-07 reveals staff finding clothing in the tenant's room soaked in urine and on 10-16-07 housekeeping staff report finding tenant's jewelry in the garbage the past two days. Nurse's notes dated 10-21-07 reveal the tenant complaining of feeling dizzy, lightheaded and seeing spots, and the tenant unable to sit or stand without help. The notes of 10-21-07 indicate a physician's order obtained with medication ordered and family notification. The tenant's service plan was not updated to reflect the changes.

- Regulatory Insufficiency: The program did not consistently ensure when a tenant needs personal care or health related-related care, the service plan would be updated as needed by the multidisciplinary team. (25.28(3))

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: Tenant #1's record review reveals physician communication dated 02-04-08 indicating the tenant had been prescribed Macrodantin and Tetracycline on 01-22-08 for urinary tract infection. Review of nurse's notes of 02-16-08 reveals the tenant complaining of "crushing chest pain with pain going down the left arm"; the tenant was transferred to the hospital at 1:40 p.m. and returned at 4:00 p.m. with no further note of the incident. Review of nurse's notes of 02-19-08 indicates an order for skin treatment with triple antibiotic ointment to the right hip daily until healed. Review of nurse's notes of 02-21-08 reveals staff called the nurse to the tenant's room to assess a blister on the tenant's penis. Review of a New Medication/Change in Medication Sheet dated 02-25-08 reveals the tenant was given an order for Bactrim DS one twice daily for 21 days for urinary tract infection. Review of nurse's notes of 03-10-08 revealed a skin tear, and a physician's order of 03-10-08 directs staff to cleanse the right upper arm with normal saline, apply tegaderm and change every 5 to 7 days until healed. Review of nurse's notes of 03-10-08 reveals an issue with the tenant's right heel. A physician's order dated 03-16-08 directs treatment to the right heel by cleanse rinsing with normal saline, apply Iodoflex and apply dressing, and instruction to notify the physician if signs of infection are present. Review of a New Medication/Change in Medication Sheet dated 03-16-08 reveals the tenant's order was extended for Bactrim DS one twice daily for 21 days for urinary tract infection. Review of a program Wound Evaluation Flow Sheet dated 04-05-08 reveals the tenant with an area on the left hip measuring 3.0 centimeters by 2.5 centimeters. There was no documentation of nurse review.

Tenant #2's record review of the nurse's notes dated 02-12-08 at 10:30 a.m. reveals the tenant to have a complaint of cold symptoms with chest congestion, stuffy nose and cough. Nurse's notes of 02-12-08 at 4:20 p.m. reveal the tenant with an oxygen saturation of 88% and the placement of oxygen at 3 liters with the tenant's oxygen saturation increasing to 94% but with breath sounds diminished throughout. The ARNP was notified 02-13-08 and an order for chest x-ray along with scheduled labs was received on 02-14-08. The tenant was admitted to the hospital on 02-15-08, with a diagnosis of pneumonia. Tenant returned to the program on 02-22-08, with a new diagnosis of diabetes, an order for Metformin 500 mg twice a day and blood glucose monitoring twice a day. There was no documentation of nurse review before or after the hospitalization.

Tenant #3, had nurse's notes of 10-12-07 indicates changes including an episode of incontinence. Nurse's notes dated 10-15-07 reveals staff finding clothing in the tenant's room soaked in urine and on 10-16-07 housekeeping staff report finding tenant's jewelry in the garbage the past two days. Nurse's notes dated 10-21-07 reveal the tenant complaining of feeling dizzy, lightheaded and seeing spots, and the tenant unable to sit or stand without help. The notes of 10-21-07 indicate a physician's order obtained with medication ordered and family notification. There was no documentation of nurse review.

- Regulatory Insufficiency: The program did not consistently ensure the Registered Nurse would assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations if there are changes in health status. (25.30(3))

D. 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: Review of three staff files revealed the staff, who operate the program handicapped accessible van, did not have the required endorsement.

- Regulatory Insufficiency: The program did not consistently ensure drivers would have appropriate driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. (25.38(6))

Dated this 21st day of May 2008.