IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

August 17, 2011

Ms. Deanna Fisher, Administrator
Cedars of Madrid
600 N. Kennedy
Madrid, IA 50156

RE: Amended Final Recertification Monitoring Evaluation Report – Cedars of Madrid, Madrid, IA

Dear Ms. Fisher:

Enclosed is the **Amended 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) and your Request for Reconsideration in response to the **Amended Final 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.

Based on the information provided, DIA accepts your Request for Reconsideration regarding Service Plan and fluids intervention for Tenant #2. The Request for Reconsideration has been denied for Tenants #2, #3, and #4 regarding nursing home preference.

Enclosed you will find the Assisted Living Program Certificate **S0176** with effective dates of **July 24, 2011** through **July 23, 2013**.

If you have any questions in regard to this certification, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Deanna Fisher, Administrator
The Cedars of Madrid
600 N Kennedy
Madrid, IA 50156

Date of Monitoring Visit:

June 8, 2011

Monitor(s):

Lori Miner, RN BSN

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. IAC r. 481-67.10(5). 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 481 IAC chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site monitoring evaluation was conducted at The Cedars of Madrid on June 8, 2011. 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:	34
Current number of tenants with cognitive disorder:	4
Total Population:	38

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 meeting was held with 10 tenants. It was reported the best thing about the program was the food, the assistance with medications, and the staff. The tenants reported the housekeeping in the apartments and common areas was done to their satisfaction. Maintenance responds quickly to requests. Staff members respond in less than five minutes to calls for assistance. The staff members were reported to treat the tenants with kindness and respect. The food was reported to be generally good and served by dietary staff. The hot foods were not always hot enough. There were generally enough activities offered, although more bingo was needed. The tenants felt safe and were generally satisfied with the program. The tenants would recommend the program to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Service Plan

Monitoring Observation: Tenant #1, (the Tenant), a 91 year-old, was admitted to the program on 7-19-01 with diagnoses of: Obsessive Compulsive Disorder, Congestive Heart Failure, History of Stroke, History of Renal Failure, Hypertension (HTN), Diverticulitis, Mild Dementia, Glaucoma, and Sjogren's Disease. On 3-16-11 the Tenant was scored at two on the Global Deterioration Scale (GDS) which indicated very mild cognitive decline.

The following tables show documentation contained in incident reports.

Date of Incident Report	Tenant found:	Treatment
3-2-11	Found on floor	"Neck hurt", no treatment
3-8-11	Found on floor	Laceration above eye, to Emergency Room for sutures
3-11-11 5:45 p.m.	Found on floor	No injury noted

3-11-11 7:30 p.m.	Leaning on rocking chair	Blood pressure 212/64. Reddened area left flank, no treatment

On 3-16-11 functional, cognitive, and health evaluations were completed for a change in condition of increased weakness and falls. The service plan was updated.

Date of Incident Report	Tenant found:	Treatment/Notes
3-20-11	Found on floor	No treatment
3-22-11	Found on floor	No treatment. Blood Pressure (BP) not documented.
3-23-11	Found on floor	Blood pressure (BP) 200/80. No treatment
3-25-11	Found on floor	No treatment
4-8-11	Found on floor	Tenderness in sacral area. No treatment. Pillow under knees to help prevent slipping downward in chair.
4-12-11	Found on floor	Knot on head, bit lip. Ice applied
4-13-11	Found on floor	No treatment. BP not documented
4-15-11	Fell out of chair, did not have call pendant on	No treatment. BP not documented
4-16-11	Found under kitchen table	No treatment. Staff checks tenant at least five times per shift.
4-17-11	Found on floor	No treatment. Forgot to use call pendant. Staff check more frequently, at least four times per shift. BP not documented

A managed risk agreement for repeated falls, dated 3-24-11, indicated rocker/swivel/recliner/glider chairs would be replaced with a solid base/lift chair.
Nurse's notes dated 3-28-11 indicated bedrails had been newly installed.
Nurse's notes dated 3-28-11 indicated the Tenant's bed was placed against the wall after a fall from bed. The service plan was not updated to include the fall interventions of frequent checks throughout the shift, the use of a pillow to keep the Tenant from sliding out of the chair, the use of a bedrail, or placement of the bed against the wall. On 4-19-11, the Tenant was discharged to a higher level of care. The service plan did not identify the Tenant's preference for nursing facility care.

Tenant #2, (the Tenant), a 91 year-old, was admitted to the program on 9-7-10 with diagnoses of: Dementia, Constipation, Benign Prostatic Hypertrophy, and Depression. The Tenant was scored at four on the GDS which indicated moderate cognitive decline. The service plan did not indicate the Tenant's preference for nursing facility care.

Tenant #3, (the Tenant), an 86 year-old, was admitted to the program on 9-21-03 with diagnosis of: High Cholesterol, HTN, Stasis Dermatitis, Arthritis, Macular Degeneration, Gout, Anemia, and History of Deep Vein Thrombosis. Nurse's notes dated 4-28-11 indicated the Tenant self-administered Lasix, an anti-diuretic, four to five times a week rather than daily as ordered. The Tenant was noted to have pitting edema and slight crackles throughout bilateral lung fields. A notation on the service plan dated 4-28-11 indicated the Tenant was noncompliant with medications and elevation of feet twice a day. The service plan did not indicate interventions for the noncompliance. In 2009 the Tenant was seen at a wound clinic for bilateral skin breakdown in the legs. A treatment flow sheet dated 9-24-09 indicated the Tenant required maintenance care for life. The health status review dated 5-23-11 indicated skin integrity would be maintained and monitored daily. Treatment sheets dated 12-17-09 and 1-28-11, provided by the program as current, indicated staff would monitor legs, feet, and toes. The service plan did not indicate interventions and monitoring for skin integrity. The service plan also did not indicate the Tenant's preference for nursing facility care.

Tenant #4, (the Tenant), an 84 year-old, was admitted to the program on 12-14-10 with diagnoses of: Cerebrovascular Accident, and Chronic Obstructive Pulmonary Disease. A health status review dated 4-12-11 indicated the Tenant slept in a recliner. Due to prolonged sitting, the buttocks was noted to have dark pink tissue with no open areas. The Tenant was encouraged to shift weight on hips. Nurse's notes dated 4-28-11 indicated the Tenant had a red fungal-type rash under an apron fold of skin. The service plan did not indicate interventions for skin integrity and also did not indicate the Tenant's preference for nursing facility care.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: the tenant's identified needs and preferences for assistance; and preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)(a,e))

B. Nurse Review

Monitoring Observation: Tenant #1, (the Tenant) had ten falls between 3-20-11 and 4-17-11. A nurse review was not completed with this series of falls. On 3-28-11 the bedtime dose of the drug Risperdal, an antipsychotic, was cut in half. The incident report dated 4-8-11 indicated the Tenant was anxious and was not feeling right since the medication was changed. The incident report dated 4-12-11 indicated the Tenant had much anxiety in the evening with crying and yelling. Nurse's notes dated 4-13-11 indicated Seroquel, an antipsychotic, was to be given in the evening. A nurse review was not completed with changes in medication and condition.

On 4-15-11, the service plan for Tenant #2 was updated to include staff assistance with bathing twice a week and dressing assistance every morning as needed. A nurse review was not completed with these service plan updates.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; and to provide the program with written documentation of the activities under the service plan, as set forth in rule 481—69.26(231C), showing the time, date and signature. (IAC r. 481-69.27(1)(3)(4))

Dated this 30th day of June, 2011.