IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

June 18, 2013

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

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

Dear Ms. Fisher:

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 **S0176** with effective dates of **July 24, 2013** through **July 23, 2015**.

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
Final Recertification Monitoring Evaluation Report

Assisted Living Program:

Deanna Fisher, Administrator
The Cedars of Madrid Homes
600 N. Kennedy
Madrid, Iowa 50156

Date of Monitoring Visit:

May 8, 2013

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	16
Number of tenants with cognitive disorder:	15
Total Population of Program at time of on-site	31
TOTAL census of Assisted Living Program	31

Tenant/Family Satisfaction Results – A community meeting was held with 9 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(s) made observations detailed in the following areas.

A. Criteria for Exclusion of Tenants

Monitoring Observation: Tenant #1, a 97 year old, was admitted on 6-22-07. Tenant #1 had the following diagnoses: Dementia with General Decline; Macular Degeneration; Depression; Poor Appetite; Atrial Fibrillation; Osteoporosis and Osteoarthritis. Tenant #1 was admitted to hospice services on 2-15-13 with the primary diagnosis of Dementia with General Decline. Tenant #1 scored a 6 on the Global Deterioration Scale (GDS) completed on 2-15-13, indicating severe cognitive decline.

According to the Health Status Review, completed on 12-24-12 due to Tenant #1's decline in health status, Tenant #1 was unable to stand and used a wheel chair for all mobility. Tenant #1 no longer used the toilet, requiring staff members to check and change incontinence products every two hours and as needed.

~~According to the functional evaluation, completed on 12-24-12, Tenant #1 required staff~~ member assistance with grooming and dressing. Tenant #1 was unable to effectively participate in bathing, being totally bathed by staff members. Tenant #1 was totally dependent in toileting, was unable to transfer but could bear weight and pivot during transfers, was chair-fast, unable to ambulate, unable to self propel his/her wheelchair and unable to feed his/her self. Tenant #1 was unable to take medications unless administered by another person.

Tenant #1's service plan, dated 12-24-12, directed staff to assist with trays for meals and to assist with meals; directed staff members to assist with bathing twice weekly (bed baths was added to the service plan on 12-31-12); directed staff members to provide incontinence care as needed, perform oral cares, dressing and undressing, changing of incontinence products and assist to toilet 4-5 times per shift or check and change 4-5 times per shift; directed staff members to reposition with pillows as often as allowed; transfer with the assist of one staff member and a gait belt; directed staff members to get tenant up into the wheelchair as often as able and indicated Tenant #1 could no longer use the pendant system on 12-31-12, giving direction for staff members to check on at least twice every shift.

According to the Nurse Review, completed on 1-23-13, Tenant #1 continued to spend most of the time lying in bed on the left side, resulting in a pressure area to the left ear. Staff members were repositioning Tenant #1. Tenant #1 was eating in his/her room with staff member assistance with feeding occasionally. Tenant #1 required "total assistance with all activities of daily living (ADLs) and required the assistance of one staff member and a gait belt to transfer into the wheel chair.

According to the Nurse Review, completed on 2-15-13, Tenant #1 had experienced a continued decline over the previous two months, becoming more dependent on staff members for all needs. Tenant #1 was unable to sit up for extended periods of time and had been sleeping more often in bed. Tenant #1 could no longer ambulate, using a wheelchair for mobility. Tenant #1 required "maximum amount of assistance for all transfers in and out of the wheel chair and required total assistance for all grooming, dressing, undressing and toileting". Tenant #1 received room trays and required staff members to feed him/her. Tenant #1 was admitted to hospice on 2-15-13 with comfort care measures requested by family members.

According to the Health Status Review, completed on 2-15-13 due to Tenant #1's decline in health status, Tenant #1 required comfort measures following an increase in weakness and general decline in health status resulting in admission to hospice services. Tenant #1 was no longer able to stand, using a wheel chair for all mobility.

According to the functional evaluation, completed on 2-15-13, Tenant #1 continued to require staff member assistance with grooming and dressing. Tenant #1 was unable to effectively participate in bathing, being totally bathed by staff members. Tenant #1 was totally dependent in toileting, was unable to transfer but could bear weight and pivot during transfers, was chair-fast, unable to ambulate, unable to self propel his/her wheelchair and unable to feed his/her self. Tenant #1 was unable to take medications unless administered by another person.

Nurses Notes, dated 2-19-13, documented Tenant #1 slept soundly most of the time, would awake at intervals and required the assistance of two staff members to get up in the wheel chair. The staff members performed perineal care, general grooming and repositioned for comfort with pillows when in bed.

Nurse Notes, dated 2-23-13, documented staff members performed full body sponge bath, dressed Tenant #1, performed grooming and transferred Tenant #1 into the wheelchair for a meal.

Hospice Care Plan Notes documented the following:

2-19-13- Tenant #1 had been requiring increased assistance from staff members with personal cares and ADLs. Tenant #1 was sleeping about 20 to 24 hours daily. Tenant #1 was incontinent of bowl and bladder, used a wheelchair for all mobility with staff member assistance to propel the wheelchair. Personal care tasks were performed by hospice aide.

2-26-13- Tenant #1 continued to sleep most of day. Tenant #1 was getting up in wheelchair only for meals then immediately back to bed. Tenant #1 was eating only bites to 25 percent of all meals with meal trays delivered to his/her apartment. Personal care tasks were performed by hospice aide.

3-12-13- Tenant #1 continued to sleep most of day, lying in bed unless up for meals. Tenant #1 had gone to the common dining room for meals that day but only ate bites during the meal. Tenant #1 began to bear weight with transfers but was unable to stand alone. Tenant #1 remained incontinent. Personal care tasks were performed by hospice aide.

3-26-13- Tenant #1 continued to sleep most of day, spending most of time in bed. Tenant #1 continued to bear weight but had not been transferring. Personal care tasks were performed by hospice aide. Tenant #1's meal intake varied.

4-10-13- Tenant #1 continued to sleep 20 to 24 hours daily. Tenant #1 was unable to bear weight during transfer. Personal care tasks were performed by hospice aide. Tenant #1 was now going to common dining room for all meals.

During interview, Staff #1, companion, reported Tenant #1 was sleeping most of the day before the hospice admission. Before the hospice admission, Tenant #1 required the assistance of one staff member and a gait belt to transfer from bed to wheelchair. Tenant #1 could not ambulate and was unable to self-propel his/her wheel chair. Tenant #1 was able to feed self but required some staff member assistance due to poor appetite, could wash his/her face during bathing but would only do on cue, did own hair care and participated some during dressing. During toileting, staff members performed care/hygiene totally. Tenant #1 would attempt to wipe self upon cue but was unable to successfully complete the task.

Staff #1 reported Tenant #1 began declining in January 2013. Tenant #1 was sleeping almost all of the time, getting out of bed infrequently, requiring staff members to reposition Tenant #1 using a turn sheet and propping with pillows. Tenant #1 got a sore on his/her ear due to lying in bed so often on one side. Tenant #1 stopped using the program's pendant system to request assistance to toilet, requiring staff members to check and change Tenant #1 in bed. Tenant #1 required staff members to totally feed him/her, had to be bathed in bed by staff members and became dependent with grooming and dressing. Tenant #1 could be transferred with the assistance of one staff member and a gait belt but no longer was able to bear any weight during the transfers. Tenant #1 was admitted to hospice services in February 2013. Tenant #1 exhibited the decline and dependence as described above until late March or early April 2013. Staff #1 reported Tenant #1 continued to require the assistance of one staff member and a gait belt to transfer from bed to wheel chair but now bears weight during the transfers.

Tenant #1 now was brought to the common dining room for meals by staff members in a wheelchair and was able to eat with little staff member assistance now. Tenant #1 was now able to use the pendant system, reporting the need to toilet which resulted in less incontinence. Tenant #1 was now able to assist minimally with dressing and grooming.

During interview, Staff #5, registered nurse (RN), reported Tenant #1 had experienced a decline which required admission to hospice services on 2-15-13. The RN reported Tenant #1 began sleeping a lot, had to be positioned by staff members when in bed, did not participate in toileting, grooming or bathing, required staff members to feed him/her for a period of approximately two weeks, required the assistance of one staff member and a gait belt when transferring, did not ambulate and could not self propel the wheelchair. Staff #5 reported she had filled out paper work to request a waiver from the Department of Inspections and Appeals due to Tenant #1's decline but did not send in to the Department after making the decision that Tenant #1 did not exceed the assisted living level of care. Staff #5 reported a belief that Tenant #1 improved, no longer requiring feeding assistance, total assistance with bathing, grooming and dressing and began using the toilet again approximately two months ago. Staff #5 reported no nurse review, evaluation or change in the service plan for Tenant #1 was done despite her reported improvement in Tenant #1's status. Staff #5 reported a plan to complete a nurse review due to Tenant #1's improvement along with the planned 90 day nurse review later this week.

During the monitor's on-site visit, Tenant #1 was pushed by staff members to the common dining room for lunch. Tenant #1 fed his/herself during the meal. Tenant #1 slept most of the afternoon and then was brought to the common area by staff members to participate in an activity.

Tenant #1 exhibited dependence with mobility, bathing, dressing, grooming, positioning and toileting from mid-January 2013 to sometime in March or April 2013. The program had not applied for a waiver with the Department of Inspections and Appeals to allow Tenant #1 to remain at the program and continued to allow Tenant #1 to remain at the program between December 24, 2012 and April 2013 despite his/her dependence with four or more ADLs.

Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

B. Nurse Review

Monitoring Observation: According to Tenant #1's Nurse Review, completed on 2-16-13, Tenant #1 had experienced a continued decline over the previous two months, becoming more dependent on staff members for all needs.

Tenant #1 was unable to sit up for extended periods of time and had been sleeping more often in bed. Tenant #1 could no longer ambulate, using a wheelchair for mobility. Tenant #1 required "maximum amount of assistance for all transfers in and out of the wheelchair and required total assistance for all grooming, dressing, undressing and toileting". Tenant #1 received room trays and required staff members to feed him/her. Tenant #1 was admitted to hospice on 2-15-13 with comfort care measures requested by family members.

Staff #1, companion, reported Tenant #1 began declining in January 2013. Tenant #1 was sleeping almost all of the time, getting out of bed infrequently, requiring staff members to reposition Tenant #1 using a turn sheet and propping with pillows. Tenant #1 got a sore on his/her ear due to lying in bed so often on one side. Tenant #1 stopped using the program's pendant system to request assistance to toilet, requiring staff members to check and change Tenant #1 in bed. Tenant #1 required staff members to totally feed him/her, had to be bathed in bed by staff members and became dependent with grooming and dressing. Tenant #1 could be transferred with the assistance of one staff member and a gait belt but no longer was able to bear any weight during the transfers. Tenant #1 was admitted to hospice services in February 2013. Tenant #1 exhibited the decline and dependence as described above until late March or early April 2013. Staff #1 reported Tenant #1 continued to require the assistance of one staff member and a gait belt to transfer from bed to wheelchair but now bears weight during the transfers. Tenant #1 now was brought to the common dining room for meals by staff members in a wheelchair and was able to eat with little staff member assistance now. Tenant #1 was now able to use the pendant system, reporting the need to toilet which resulted in less incontinence. Tenant #1 was now able to assist minimally with dressing and grooming.

During interview, Staff #5, RN, reported Tenant #1 had experienced a decline which required admission to hospice services on 2-15-13. The RN reported Tenant #1 began sleeping a lot, had to be positioned by staff members when in bed, did not participate in toileting, grooming or bathing, required staff members to feed him/her for a period of approximately two weeks, required the assistance of one staff member and a gait belt when transferring, did not ambulate and could not self propel the wheelchair. Staff #5 reported she had filled out paper work to request a waiver from the Department of Inspections and Appeals due to Tenant #1's decline but did not send in to the Department after making the decision that Tenant #1 did not exceed the assisted living level of care. Staff #5 reported a belief that Tenant #1 improved, no longer requiring feeding assistance, total assistance with bathing, grooming and dressing and began using the toilet again approximately two months ago. Staff #5 reported no nurse review, evaluation or change in the service plan for Tenant #1 was done despite her reported improvement in Tenant #1's status. Staff #5 reported a plan to complete a nurse review due to Tenant #1's improvement along with the planned 90 day nurse review later this week.

Tenant #1 improved in his/her functional abilities (eating, toileting, grooming and dressing) sometime in March or April 2013. The program RN did not complete a nurse review at the time of the noted improvement.

Regulatory Insufficiency: 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 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. (IAC r. 481-69.27(1))

C. Evaluation of Tenant

Monitoring Observation: According to Tenant #1's Nurse Review, completed on 2-16-13, Tenant #1 had experienced a continued decline over the previous two months, becoming more dependent on staff members for all needs. Tenant #1 was unable to sit up for extended periods of time and had been sleeping more often in bed. Tenant #1 could no longer ambulate, using a wheelchair for mobility. Tenant #1 required "maximum amount of assistance for all transfers in and out of the wheelchair and required total assistance for all grooming, dressing, undressing and toileting". Tenant #1 received room trays and required staff members to feed him/her. Tenant #1 was admitted to hospice on 2-15-13 with comfort care measures requested by family members.

Staff #1, companion, reported Tenant #1 began declining in January 2013. Tenant #1 was sleeping almost all of the time, getting out of bed infrequently, requiring staff members to reposition Tenant #1 using a turn sheet and propping with pillows. Tenant #1 got a sore on his/her ear due to lying in bed so often on one side. Tenant #1 stopped using the program's pendant system to request assistance to toilet, requiring staff members to check and change Tenant #1 in bed. Tenant #1 required staff members to totally feed him/her, had to be bathed in bed by staff members and became dependent with grooming and dressing. Tenant #1 could be transferred with the assistance of one staff member and a gait belt but no longer was able to bear any weight during the transfers. Tenant #1 was admitted to hospice services in February 2013. Tenant #1 exhibited the decline and dependence as described above until late March or early April 2013. Staff #1 reported Tenant #1 continued to require the assistance of one staff member and a gait belt to transfer from bed to wheel chair but now bears weight during the transfers. Tenant #1 now was brought to the common dining room for meals by staff members in a wheelchair and was able to eat with little staff member assistance now. Tenant #1 was now able to use the pendant system, reporting the need to toilet which resulted in less incontinence. Tenant #1 was now able to assist minimally with dressing and grooming.

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Staff #5 reported a belief that Tenant #1 improved, no longer requiring feeding assistance, total assistance with bathing, grooming and dressing and began using the toilet again approximately two months ago. Staff #5 reported no nurse review, evaluation or change in the service plan for Tenant #1 was done despite her reported improvement in Tenant #1's status. Staff #5 reported a plan to complete a nurse review with corresponding health, functional and cognitive evaluations due to Tenant #1's improvement along with the planned 90 day nurse review later this week.

Tenant #1 improved in his/her functional abilities (eating, toileting, grooming and dressing) sometime in March or April 2013. The program RN did not complete an evaluation of Tenant #1's health, functional and cognitive status at the time of the noted improvement.

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))