

INSPECTIONS & APPEALS

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TERRY E. BRANSTAD
GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

KIM REYNOLDS
LT. GOVERNOR

December 19, 2014

Ms. Kristen Milledge, Administrator
Homestead of Chariton
1110 N. 6th Street
Chariton, IA 50049

RE: Final Recertification Monitoring Evaluation Report – Homestead of Chariton, Chariton, IA

Dear Ms. Milledge:

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, following a survey by DIA on **December 16, 2014**. The Report notes a Regulatory Insufficiency in the area(s) of: Record Checks.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/mailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

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.

Also enclosed you will find the Assisted Living Program Certificate **S0233** with effective dates of **May 10, 2014** through **May 9, 2016**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOMESTEAD OF CHARITON

**1110 NORTH 6TH STREET
CHARITON, IA 50049**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments 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 No. of tenants without cognitive disorder: 35 No. of tenants with cognitive disorder: 2 Total Population of Program at time of visit 37 TOTAL census of Assisted Living Program 37 The following insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on a review of background checks for four employees and interviews, a background check was not completed prior to employment at the program. Background checks were reviewed for four	A 118		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 118	Continued From page 1 employees. 1. Staff A, hired as a dietary aide, had a timecard which indicated Staff A worked at the program beginning on 6-5-14. Staff A worked 12 days between 6-5 and 6-22-14. The program provided documentation of a background check completed through SING on 6-25-14. Staff A was not found on the child abuse or dependent adult abuse registries. Staff A did not have a criminal history identified through SING. In an interview with the Executive Director on 12-16-14 at 10:40 a.m., she stated she found no documentation of any other background checks completed for Staff A. The background checks for Staff A were not completed prior to employment at the program.	A 118		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CHARITON	STREET ADDRESS, CITY, STATE, ZIP CODE 1110 NORTH 8TH STREET CHARITON, IA 50049
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DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

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DIVISION OF HEALTH FACILITIES - STATE OF IOWA
STATE FORM

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If continuation sheet 2 of 2