IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

October 14, 2015

Complaint Intake #: 54315-C

Ms. Jeanine Chartier, Administrator
Char-Mac AL of Holstein
1500 South Kiel
Holstein, IA 51025

RE: Final Recertification Monitoring Evaluation & Complaint Investigation Report – Char-Mac AL of Holstein, Holstein, IA

Dear Ms. Chartier:

Enclosed is the **Final Recertification Monitoring Evaluation & Complaint Investigation 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. In addition to the recertification evaluation, the department investigated the following complaint #54315-C. Based on observations, staff interviews, and review of tenant files, discharged files, incident reports, program policies, the following was found:

1. Service Plans-Unsubstantiated
   Comments: Four Program staff and 16 tenants were interviewed. Five tenant files were reviewed. Cognitive, functional, and health evaluations were conducted as required and service plans implemented and updated according to tenant needs.

2. Staffing-Unsubstantiated
   Comments: Four Program staff and 16 tenants were interviewed. Four staff files were reviewed. Program staff were trained and provided services to tenants according to tenant needs.

No Regulatory Insufficiencies were found during this evaluation.

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 **S0222** with effective dates of **November 22, 2015** through **November 21, 2017.**

If you have any questions in regard to this certification, 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0222	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAR-MAC AL OF HOLSTEIN	1500 SOUTH KIEL HOLSTEIN, IA 51025

(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 Number of tenants without cognitive disorder: 41 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 43 TOTAL census of Assisted Living Program: 43 A recertification visit and complaint investigation #54315-C were conducted at the Program on 9/17/15 and 9/22/15. No regulatory insufficiencies were written as a result of the recertification or investigation.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE