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 |
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| A 000 | 481-67 Initial Comments<br><br>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.<br><br>Dementia-Specific by Definition<br><br>Number of tenants without cognitive disorder: 37<br>Number of tenants with cognitive disorder: 6<br>Total Population of Program at time of on-site: 43<br><br>Dementia-Specific Program by Dedication<br><br>Number of tenants without cognitive disorder: 0<br>Number of tenants with cognitive disorder: 10<br>Total Population of Program at time of on-site: 10<br><br>TOTAL census of Assisted Living Program: 53<br><br>No regulatory insufficiencies were cited during the investigation of Incidents # 61647-I and 61648-I, and Complaint #60299-C.<br><br>The following regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program: | A 000 | | |
| A 003 | 481-67.2 Program policies and procedures<br><br>481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a | A 003 | | |

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

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| A 003 | Continued From page 1<br>program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, policy review, and a review of response system records, the Program failed to follow its policy for response to call lights.<br>Findings follow:<br><br>1. A tenant meeting was held with approximately 30 tenants. Tenants reported it took staff 15 to 30 minutes to respond to requests for assistance when the call light was used.<br><br>Review of the policy on the Personal Response System revealed staff should respond to a page within five minutes.<br><br>Review of call response logs from 7-3-16 to 8-2-16 revealed more than 80 responses took more than 15 minutes; approximately seven of the 80+ responses took more than 30 minutes, and one took 56 minutes for a response. | A 003 | | |
| A 083 | 481-69.26(1) Service Plans<br><br>481-69.26(231C) Service plans.<br>69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. | A 083 | | |

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| A 083 | Continued From page 2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and a review of six tenant files and observation, the Program failed to ensure service plans met the specific service needs of the tenants. Findings follow:<br><br>1. Tenant #1, an 81 year-old, was admitted on 6-11-12 and had diagnoses of: dementia, hypertension, and anxiety. Tenant #1 was staged at five on the global deterioration scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in the secured dementia unit.<br><br>Tenant #1's elopement risk assessment, completed on 5-18-16, revealed he/she scored 28 points. The assessment directed 15 or more points indicated a tenant at risk for elopement and further directed the service plan should be updated.<br><br>Clinical notes dated 5-23-16, 6-14-16, and 6-26-16 documented Tenant #1 was "eyeballing" the door, trying to leave, or exiting the dementia unit.<br><br>A review of the negotiated services agreement (service plan), dated 5-18-16, failed to identify Tenant #1 as an elopement risk or exit seeking and failed to identify interventions to address exit seeking.<br><br>2. Tenant #3, an 87 year-old, was admitted on 3-21-16 and had diagnoses of: hypertension, diabetes,and gastroesophageal reflux disease | A 083 | | |

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| A 083 | Continued From page 3<br>(GERD). Tenant #3 was admitted into hospice on 2-12-16 for lung cancer.<br><br>Clinical notes dated 4-5-16 documented Tenant #3's change of condition, and noted the tenant had a drain located in the right posterior lung area.. The service plan, dated 4-8-16, documented staff should assist with bathing as needed; however, the plan failed to identify care of the drain in the lung area during bathing.<br><br>Tenant #3's clinical notes dated 5-10-16 documented an indwelling catheter inserted into the bladder. The facility failed to update Tenant #3's service plan with his/her change of condition. The service plan failed to identify the use of the catheter or the care of the catheter.<br><br>3. Tenant #4, an 86 year-old, was admitted on 7-22-16 and had diagnoses of: dementia, GERD, history of falls, and anxiety. On 7-19-16 Tenant #4 was staged at five on the GDS, which indicated moderately severe cognitive decline. Tenant #4 resided in the secured dementia unit.<br><br>Observations on 8-2-16 at 2:00 p.m. revealed Staff D and Staff H transfer Tenant #4. Tenant #4 was noted to have a bulge in the right upper arm.<br><br>Review of Tenant #4's clinical notes revealed the following:<br>a. Notes dated 7-23-16 documented Tenant #4 unable to feed himself/herself.<br>b. Notes dated 7-24-16 documented Tenant #4 required the assist of two for transfer.<br><br>When interviewed on 8-2-16, Staff D stated Tenant #4 required two persons for transfer, and did not assist with eating. Staff D reported Tenant #4 could not lift his/her arm. | A 083 | | |

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| A 083 | Continued From page 4<br><br>When interviewed on 8-2-16 stated Tenant #4 took two persons to assist with transfers, and had a "dislocated" right arm which made transfers and eating difficult. Staff H reported Tenant #4 could not feed himself/herself.<br><br>During an interview on 8-3-16, the Regional Nurse stated she completed re-evaluation of Tenant #4, as the Program nurse had resigned and had left the Program the week before the onsite visit. The Regional Nurse had spoken with physical therapy and learned Tenant #4 was not expected to improve and would require the assist of two for transfers. The Regional Nurse stated the family was notified of the need for Tenant #4 to transfer out of the Program.<br><br>A review of Tenant #4's service plan dated 7-19-16 revealed the plan failed to identify the need for two persons for transfer and the tenant's inability to feed himself/herself. | A 083 | | |
| A 086 | 481-69.26(3)a Service Plans<br><br>481-69.26(231C) Service plans.<br>69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant ' s occupancy and as needed with significant change, but not less than annually.<br>a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.<br><br>This REQUIREMENT is not met as evidenced | A 086 | | |

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| A 086 | Continued From page 5<br>by:<br>Based on interview and review of tenant files, the Program failed to ensure updated service plans were signed and dated by all parties. Findings follow:<br><br>1. Tenant #1, an 81 year-old, was admitted on 6-11-12 and had diagnoses of: dementia, hypertension, and anxiety. Tenant #1 was staged at five on the global deterioration scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in the secured dementia unit.<br><br>Clinical notes dated 5-18-16 documented Tenant #1 had behavioral changes. The negotiated service agreement (service plan) was updated as a result; however, the service plan was not signed by the nurse and tenant or legal representative.<br><br>2. Tenant #2, a 92 year-old, was admitted on 12-26-15 and had diagnoses of: dementia, history of falls, history of urinary infection, and hypertension. Tenant #2 was staged at five on the GDS, which indicated moderately severe cognitive decline. Tenant #2 resided in the section of the building deemed dementia-specific by definition.<br><br>Clinical notes dated 4-22-16 documented Tenant #2 experienced a change of condition related to falls, urinary infection, and hospitalization. The service plan dated 4-22-16 was not signed by the nurse and tenant or legal representative.<br><br>Clinical notes dated 6-13-16 documented Tenant #2 experienced a change of condition related to falls and urinary infection. The negotiated services agreement dated 6-13-16 was not signed by the nurse and tenant or legal | A 086 | | |

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| A 086 | Continued From page 6<br>representative.<br><br>3. Tenant #3, an 87 year-old, was admitted on 3-21-16 and had diagnoses of: hypertension, diabetes,and gastroesophageal reflux disease (GERD). Tenant #3 was admitted into hospice on 2-12-16 for lung cancer.<br><br>Clinical notes dated 4-5-16 documented Tenant #3 had a change of condition and required additional assistance. The negotiated services agreement dated 4-8-16 was not signed by the nurse or tenant.<br><br>4. Tenant #5, a 74 year-old, was admitted on 12-19-15 and had diagnoses of: dementia, hypertension, and GERD. Tenant #5 was staged at five on the GDS, which indicated moderately severe cognitive decline. Tenant #5 resided in the secured dementia unit.<br><br>Evaluations of Tenant #5's function, cognition, and health were completed on 6-17-16 and the negotiated service agreement was updated on the same date. The service agreement revealed signatures were required; however, the negotiated service agreement, dated 6-17-16, was not signed by the nurse and tenant or legal representative.<br><br>5. Tenant #6, an 84 year-old, was admitted on 2-6-12 and had diagnoses of: dementia, hypertension, osteoarthrosis, and leukemia. Tenant #6 was staged at six on the GDS, which indicated severe cognitive decline. Tenant #6 resided in the secured dementia unit. Tenant #6 was admitted into hospice on 6-13-13 with a diagnosis of dementia.<br><br>Evaluations of Tenant #6's function, cognition, | A 086 | | |

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| A 086 | Continued From page 7<br>and health were completed on 3-31-16 and the negotiated service agreement was updated on the same date. The service agreement documented that to be effective, the signature of all participants was required. The negotiated service agreement dated 3-31-16 was not signed by the nurse and tenant or legal representative.<br><br>When interviewed on 8-2-16 and 8-3-16 the Regional Nurse stated she was unable to locate signed service plans for Tenants #1, #2, #3, #5, and #6. | A 086 | | |
| A 094 | 481-69.27(1)a Nurse Review<br><br>481-69.27(231C) Nurse review. 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:<br>69.27(1)a 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of tenant files, the program failed to consistently monitor tenant medications. Findings follow: | A 094 | | |

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| A 094 | Continued From page 8<br><br>1. Tenant #1, an 81 year-old, was admitted on 6-11-12 and had diagnoses of: dementia, hypertension, and anxiety. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the secured dementia unit.<br><br>Clinical notes included a review completed 5-18-16, and noted Tenant #1 had behavioral changes. The negotiated service agreement (service plan), also dated 5-18-16, documented Tenant #1 received medications administered by the Program.<br><br>The review completed 5-18-16 failed to monitor for adverse reactions to medications, ensure medication orders were current, and ensure medications were administered consistent with orders.<br><br>2. Tenant #2, a 92 year-old, was admitted on 12-26-15 and had diagnoses of: dementia, history of falls, history of urinary infection, and hypertension. Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #2 resided in the section of the building deemed dementia-specific by definition. The clinical record contained documentation of administration of medications by the Program.<br><br>Clinical notes dated 4-22-16 documented Tenant #2 experienced a change of condition related to falls, urinary infection, and hospitalization.<br><br>Clinical notes dated 6-13-16 documented Tenant #2 experienced a change of condition related to falls and urinary infection. | A 094 | | |

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| A 094 | Continued From page 9<br><br>Reviews completed 4-22-16 and 6-13-16 failed to monitor for adverse reactions to medications, ensure medication orders were current, or ensure medications were administered consistent with orders.<br><br>3. Tenant #5, a 74 year-old, was admitted on 12-19-15 and had diagnoses of: dementia, hypertension, and gastroesophageal reflux disease (GERD). Tenant #5 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #5 resided in the secured dementia unit.<br><br>Clinical notes dated 3-31-16 documented a 90-day review completed. Notes dated 6-17-16 documented a six month review completed. Both reviews documented the Program administered medications to Tenant #5.<br><br>The reviews of 3-31-16 and 6-17-16 failed to monitor for adverse reactions to medications, ensure medication orders were current, or ensure medications were administered consistent with orders.<br><br>4. Tenant #6, an 84 year-old, was admitted on 2-6-12 and had diagnoses of: dementia, hypertension, osteoarthrosis, and leukemia. Tenant #6 was staged at six on the GDS which indicated severe cognitive decline. Tenant #6 resided in the secured dementia unit. Tenant #6 was admitted into hospice on 6-13-13 with a diagnosis of dementia.<br><br>A review of the negotiated service agreement dated 3-31-16 documented the Program administered medications to Tenant #6. | A 094 | | |

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| A 094 | Continued From page 10<br>Clinical notes dated 6-16-16 documented a 90-day review was completed, but failed to include monitoring for adverse reactions to medications, ensure medication orders were current, or ensure medications were administered consistent with orders.<br><br>The Regional Nurse was interviewed on 8-2-16 and confirmed reviews of medications were not completed. | A 094 | | |
| A 111 | 481-69.28(6)d Food Service<br><br>481-69.28(231C) Food service.<br>69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following:<br>d. Appropriately trained staff may prepare in the program ' s kitchen individual quantities of tenant-requested menu-substitution food items that require limited or no preparation, such as peanut butter or cheese sandwiches or a single-service can of soup. The food items necessary to prepare the menu substitution may be stored in the program ' s kitchen. These food items may not be cooked in the program ' s kitchen but may be reheated in a microwave. A two- or four-slice toaster may be used for tenant-requested menu-substitution items, but no bare-hand contact is permitted.<br><br>This REQUIREMENT is not met as evidenced | A 111 | | |

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| A 111 | Continued From page 11<br>by:<br>Based on observation, interview, and review of the Food Code, the Program failed to ensure the dementia unit met the standards of state laws and ordinances pertaining to the service of food. Findings follow:<br><br>1. Observation on 8-2-16 at 4:30 p.m. revealed meal service in the dementia unit. Staff D and Staff E plated french fries, hamburgers, buns, lettuce and tomato. Staff D and Staff E did not wash hands prior to donning gloves. Staff D and Staff E also failed to apply a hair net prior to plating the food.<br><br>A review of the Food Code 2-301.14(H) revealed food employees shall clean their hands before donning gloves for working with food. Food Code 2-402.11 revealed food employees shall wear hair restraints.<br><br>2. Further observation on 8-2-16 at 4:30 p.m. revealed Staff D took the french fries out of the warmer and placed the fries on 10 cold plates. Staff D then proceeded to place the hamburger buns and the burgers on the plates. Staff D stated she did not take the temperature of the food prior to serving.<br><br>The Cook was asked to come to the dementia unit and at 4:42 p.m. Prior to the serving of the food, the Cook determined the temperature of the french fries on the plate was 80 degrees. The Cook stated the temperature of the fries was to be 145 degrees. | A 111 | | |
| A 121 | 481-69.30(1) Dementia Specific Education for Personnel | A 121 | | |

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| A 121 | Continued From page 12<br>481-69.30(231C) Dementia-specific education for program personnel.<br>69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of staff training files the program failed to ensure staff received eight hours of dementia-specific education and training within 30 days of employment. This pertained to 3 of 4 staff files reviewed for persons employed within the last 12 months. Findings follow:<br><br>Record review revealed the following:<br><br>1. Staff A was hired on 8-26-15. The Program provided documentation Staff A watched dementia videos on 8-26-15.<br><br>2. Staff D was hired on 4-19-16. According to the Executive Director, Staff D had previously been employed by the Program and was re-hired on 4-19-16. The Program provided documentation Staff D watched dementia videos on 11-25-15.<br><br>3. Staff F was hired on 4-11-16. The Program provided documentation Staff F watched dementia videos on 4-13-16.<br><br>A review of the video discs revealed the videos ran for approximately 160 minutes, or less than three hours. | A 121 | | |

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 |
|---|---|---|---|
| | S0151 | A BUILDING _____ B WING _____ | C 08/04/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD OF CENTERVILLE | 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544 |

| (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 121 | Continued From page 13<br>When interviewed the Executive Director confirmed the videos were less than three hours long. The Program failed to provide any additional documentation of dementia training for staff. | A 121 | | |
| A 147 | 481-69.33(6) Transportation<br><br>481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program:<br>69.33(6) The driver shall have a valid and appropriate Iowa driver ' s license or commercial driver ' s license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of driver's licenses provided by the Program and the Iowa Department of Transportation 2016-2017 truck guide, the program failed to ensure drivers of vehicles obtained the appropriate driver's license. Findings follow:<br><br>Review of employee driver's licenses revealed the following:<br><br>1. Staff A had a Class C non-commercial driver's license.<br><br>When interviewed on 8-2-16, Staff A confirmed she transported tenants in Program vehicles if | A 147 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0151 | A. BUILDING: _____ B. WING _____ | C 08/04/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD OF CENTERVILLE | 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544 |

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|---|---|---|---|---|
| A 147 | Continued From page 14<br>needed.<br><br>2. Staff B had a Class C non-commercial driver's license.<br><br>3. Staff C had a Class C non-commercial driver's license. When interviewed on 8-1-16 Staff C reported she drove the car to transport tenants.<br><br>Review of the Iowa Department of Transportation 2016-2017 truck guide (page 14)identified a Class D-3 license required for persons paid or compensated to transport passengers.<br><br>When interviewed on 8-1-16 the Executive Director reported Staff A, Staff B, and Staff C all drove Program vehicles to transport tenants as part of the job. | A 147 | | |
| A 226 | 481-69.30(3)b Dementia-Specific Education for Personnel<br><br>69.30(3) Dementia-specific continuing education<br>b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of staff training files and interview the Program failed to ensure direct contact personnel received eight hours of annual dementia-specific continuing education annually. This pertained to 2 of 2 files reviewed of | A 226 | | |

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 |
|---|---|---|---|
| | S0151 | A. BUILDING: _____ B. WING _____ | C 08/04/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD OF CENTERVILLE | 19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544 |

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|---|---|---|---|---|
| A 226 | Continued From page 15<br>staff employed by the program greater than a year. Findings follow:<br><br>1. Staff G was hired on 1-7-15. The Program provided documentation of one hour of dementia training on 6-17-15 and 7-7-15, but failed to provide documentation of dementia training in the last 12 months.<br><br>2. Staff H was hired on 10-1-10. The Program provided documentation of one hour of dementia training on 3-15-16 and 4-27-16.<br><br>On 8-3-16 the Executive Director stated she was unable to provide any further documentation related to dementia training. | A 226 | | |

9/6/16

8/29/16

To: Department Of Inspections and Appeals, Division of Health Care Facilities

RE: Recertification August 4-8, 2016

Plan of correction for Homestead of Centerville Assisted Living

- Tag A003 Program Policies and Procedures

The program does have a policy and procedure regarding responding to emergency call lights. We will make sure that the staff are trained on the expectations of how and when to respond to call lights. We updated the current policy to make it a more reasonable time and we are running random audits of the paging system to ensure we are following our own policy and that the residents' needs are being met and in an appropriate amount of time.

- Tag A083

The program will develop service plans to meet each residents individualized care needs, in accordance with regulation 481-69.26(1) , 69.22(1) and 69.22(2). The proper assessments will be completed to accurately reflect the specific needs of the tenant on the service plan. Audits by the Executive Director and ongoing quality assurance visits by the regional team will be completed to monitor compliance.

- Tag A086

The program will develop service plans in accordance with regulation 481-69.26 (3). The tenant service plans shall be signed and dated by all parties. The program nurse will be trained on how to complete service plans and the proper procedure regarding the proper signatures required. The Executive Director and audits performed by the quality assurance team will be monitoring that all tenant service plans will be signed by all parties.

- Tag A094

The program nurse will complete Nurse Reviews in accordance with regulation 69.27 (1). The program nurse will be trained to monitor, at least every 90 days, or after a significant change in the tenants condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate referrals, and to ensure that the prescription medications orders are current and that the prescription medications are administered consistent with such orders. A tracking system has been developed to track when the 90 day evaluations of tenants are due. The tracking system will be monitored by the Executive Director and the quality assurance team to ensure compliance.

- Tag A111

The program will meet the standards of the Food Code(s) 2-301. 14(H) stating that food employees shall clean their hands prior to gloving hands and serving food. 2-402.11 food employees shall wear hairnets. Food shall be tempted prior to serving so it has reached the proper serving temperature. Training of all staff serving and handling food will be completed by the Dietary Manager and all staff will complete safe food handling training prior to handling and serving food. Documentation of such training will be kept. This will also be completed on a yearly basis. Documentation of temping of food will be done and kept in the serving area. The Executive Director, the Dietary Manger and the quality assurance team will be monitoring for compliance.

- Tag A21

Dementia-specific education for program personnel will be completed in accordance with 481-69.30 (231C)

Staff will have 8 hours of dementia specific training in the first 30 days of employment and annually thereafter. A tracking system will be put in place to ensure compliance is met in the appropriate time frame. The program will make sure that the time of the videos and hands on training meet the guidelines. The Executive Director and the quality assurance team will monitor for compliance.

- Tag A147

Transportation

Staff that provide transportation services to tenants shall have a valid and appropriate driver's license as required by law for the vehicle being utilized according to regulation 481-69.33(231C).

All staff that is currently transporting tenants has the proper drivers' license and a copy is in personnel file. Executive Director will make sure that we have a valid drivers license on file at all times. This will be monitored by the quality assurance team and the Executive Director.

- Tag A226

Dementia -specific education. Staff working in a Dementia-specific program shall have a minimum of 8 hours of dementia-specific training annually according to regulation481-69.30(3) b. The Executive Director will keep documentation of the training completed by the staff. The Executive Director and the quality assurance team will monitor for compliance.

All regulatory insufficiencies will be corrected within 30 days from receipt of this Statement of Deficiencies, which is September 15, 2016. We are currently working on getting all care plans reviewed and getting all of the appropriate signatures. We are trying to get them all completed by the end of the 30 days of this Statement of Deficiencies, and have gotten many done, but in case of a revisit and they are all not quite completed I am wanting the Department to know that we are working hard to get them all completed to be compliant.

Please accept all of the above as our Plan of Correction for Homestead of Centerville. Please let me know if you have any questions or concerns.

Best Regards,

Kristen Arbogast

Kristen Arbogast, Executive Director

Homestead of Centerville, 641-437-1999

karbogast@homesteadofcenterville .com