IOWA

Citation

Assisted living programs: Iowa Code 231C and 321 IAC Chapter 25, 26, and 27; IAC 661--5.626 Assisted Living Housing (Life Safety)

Residential care facilities: IAC Chapter 57 and Chapter 60

Related codes that affect but do not specifically reference assisted living: 655 IAC Chapter 6-Nurse Practice; 645 IAC Chapter 63-Salons; Iowa Code Chapter 155A-Pharmacy; 481 IAC Chapters 30 & 32-Food Service Establishments

General Approach and Recent Developments

Revisions to the regulations were effective May 14, 2004. During the past few years, the level of care provided has received attention. Assisted living programs are viewed as a point along a continuum of settings and not appropriate for people who are dependent in ADLs, have late-stage dementia or compromised health conditions.

Responsibility for oversight and monitoring was transferred from the Department on Aging to the Department of Inspection and Appeals. The Department on Aging retains responsibility for issuing regulations. The shift has changed the monitoring from responding to events triggered by complaints to examining program operations and practices in relation to the regulations. The State continues to emphasize consumer choice and autonomy. The nursing and social work staff responsible for oversight are located in a separate monitoring (rather than survey) unit which is separate from the institutional survey staff.

A task force will issue a report recommending creation of a Medicaid assisted living benefit and a payment that includes waiver and state plan services.

SUPPLY						
Category	2004		2002		2000	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living programs	184	5,220*	154	4,180*	78	3,409
* The total capacity is 8,246 in 2004 and 6,199 in 2002, including double occupancy units.						

Definition

"Assisted living means provision of housing with services which may include, but are not limited to, health related care, personal care and assistance with instrumental activities of daily living to six or more tenants in a physical structure which provides a home-like environment. Assisted living also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence. Assisted living includes the provision of housing and assistance with instrumental activities of daily

living only if personal care or health related care is also included." 96 Acts, Chapter 1192. SF 2193 modified the definition by including housing and IADLs only if personal care and health related services are included.

A dementia-specific assisted living program means an assisted living program that either serves five or more tenants with dementia or cognitive disorder at Stage 4 or above on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Unit Requirements

Assisted living programs may have private dwelling units with lockable doors and individual cooking facilities. In facilities built before July 2001, units must have at least one room with not less than 120 square feet of floor area. Other habitable rooms must have at least 70 square feet. Each single occupancy dwelling unit in buildings built after July 2001 must have at least 240 square feet of floor area, excluding bathrooms. Units used for double occupancy must have at least 340 square feet, excluding bathrooms. The space requirements are lower for dementia units.

Admission/Retention Policy

Programs may not admit or retain tenants who are bedbound, require two person assistance with standing, transfer or evacuation; pose a danger to self or others; are in an acute stage of alcoholism, drug addiction or uncontrolled mental illness; are under age 18; require more than part-time or intermittent health related care (21 days); on a routine basis have unmanageable incontinence; or meet the program's transfer criteria. Part-time or intermittent nursing care includes licensed nursing care for unstable conditions, daily medication injections (except stable diabetes), daily assessment or treatment of conditions such as an open wound or pressure ulcer, total care for unmanageable incontinence, or routine two-person assistance with standing, transfer, or evacuation. Managed risk statements must be used. The facilities policy is stated in the application for certification.

Exceptions to the limit on part-time or intermittent health care may be requested for residents who need hospice care or temporarily need more than part-time or intermittent health care for more than 21 days. Approvals may be given for limited time periods if the resident makes an informed choice to remain, the program has the staff to meet the extended needs, and the health and welfare of other tenants is not jeopardized.

Nursing Home Admission Policy

Intermediate level of care can be approved if the individual requires daily supervision with dressing and personal hygiene in conjunction with one of the following: cognitive functions, mobility, skin, pulmonary status, continence, physical functioning--

eating, medications, communication/hearing/vision patterns, or prior living circumstances--psychosocial.

Intermediate level of care can also be approved if the individual requires physical assistance by one or more persons to perform dressing and personal hygiene.

Services

The certification application includes the process for assessing tenants' functional and cognitive ability and a copy of the assessment tool. Individualized service plans are required. Programs must provide some personal care or health related services and at least one meal a day. Health related services mean less than daily skilled nursing services and professional therapies for temporary but not indefinite periods of time of up to 21 days a month. Skilled services and therapies combined with personal care and nurse delegated activities may not total more than eight hours a day. Service plans must be developed for each tenant, and plans for tenants needing personal care or health related services must be developed with a multidisciplinary team (including a health professional and human services professional) and the tenant.

The rules allow a managed risk statement which includes the tenant's or responsible person's signed acknowledgment of the shared responsibility for identifying and meeting needs and the process for managing risk and upholding tenant autonomy when tenant decision making may result in poor outcomes for the tenant or others.

Dietary

Facilities must have the capacity to provide hot or other appropriate meals at least once a day or to coordinate with other community providers to make arrangements for the availability of meals. Therapeutic diets may be provided.

Agreements

Each tenant signs an occupancy agreement and managed risk statement prior to occupancy. The agreement includes a shared responsibility/managed risk policy, all fees, charges, and rates describing tenancy and basic services covered, any additional and optional services and their cost. It also includes a statement regarding the impact of the fee structure on third party payments and whether they will be accepted by the program; procedure for non-payment of fees; identification of the person responsible for making payment; guarantee of a 30-day written notice of any changes in the agreement unless the tenant's health status or behavior creates a substantial threat to health and safety; occupancy and transfer criteria; grievance policies; emergency response policy; the staffing policy including whether or not staff are available 24-hours a day, whether delegation will be used and how staffing will be adapted to meet changing needs. Additional provisions are added for programs serving people with dementia; refund policy; statement regarding billing, telephone number to make a complaint; a copy of the

tenant's rights provisions; and a statement that tenant landlord law applies to assisted living programs.

Provisions for Serving People with Dementia

Units built in a neighborhood design offer 150 square feet of floor excluding bathroom for single occupancy and 250 square feet for double occupancy. The difference in square footage must be added to the common areas. Facilities must have an operating door alarm system. Visual or audible alarms may be disconnected if it is disruptive to a tenant. The tenant agreement must include a description of the services and programming.

Programs must have a system, program, or staff procedure that responds to emergency needs in lieu of a personal emergency response system. Training for all employees includes 6 hours on specified topics that include: explanation of the disease; philosophy and program; skills for communicating with residents and family; family issues; importance of planned and spontaneous activities; providing ADL assistance; service planning and social history; working with challenging tenants; simplifying cuing and redirecting; and staff support and stress reduction.

Medication Administration

Written medication plans are required. Medications may be administered in accordance with state rules governing administration. Nurse delegation rules allow administration and supervision of routine, oral medications by trained unlicensed personnel. Registered nurses may delegate injections to licensed nursing staff. Delegation rules are issued by the Board of Nursing. Registered nurses must monitor administration, ensure orders are current and are administered consistent with the orders. They must also document the resident's health status and progress every 90 days.

Public Financing

Assisted living is covered through a Medicaid HCBS waiver, state service funds, and a state funded rent supplement program.

Medicaid: Certified or accredited assisted living programs may be providers of Medicaid home and community based waiver services including: assistive devices, chore, consumer directed attendant care, emergency response, home delivered meals, home health aide, homemaker, nursing, nutritional counseling, respite, senior companions, and transportation.

Services are reimbursed on a fee-for-services basis according to the care plan. There is a maximum cap of $1,025 per month on care plans.

One affordable facility has opened under the Coming Home Program. The Iowa Finance Authority will be tracking the state/federal dollar savings on a monthly basis. The State estimates that it saves $905.52 a month in state and federal Medicaid expenditures for each resident served.

MEDICAID PARTICIPATION					
2004		2002		2000	
Facilities	Participation	Facilities	Participation	Facilities	Participation
73	126	54	129	12	NR

The SSI payment standard is $564 and the personal needs allowance is $30. The resident's room-and-board payment is separate from the Medicaid service amount. The State uses the 300 percent Medicaid eligibility option. Residents may retain up to $1,692 a month of their income to cover room and board and other costs. Family supplementation of resident income for room and board costs is allowed up to the $1,692 limit.

State Supplementary Assistance: This state funded program provides up to $483 a month in payments for in-home health related services that are not covered under other programs or for HCBS assisted living residents who need more care than is available under the service cap. Services may include nursing and personal care tasks when certified by a physician that the services can be provided in a person's home, including assisted living.

State rental assistance program: This program works like HUD's Section 8 program and pays rental expenses for low income beneficiaries who do not have access to rent subsidies. Beneficiaries pay 30 percent of their income for rent. The program can pay the difference between the tenant's payment and the fair market rent set by HUD. Participants must be eligible for waiver services. A special one-time grant of $500 is available to pay for household furnishings and supplies for people who are moving from an institution.

Staffing

Sufficient staffing must be available at all times to meet the needs of residents. Programs administering medications or providing health related services must provide for a registered nurse to monitor medications, ensure physician orders are current (30 days), and assess and monitor health status (90 days). Each program must provide access to a 24-hour emergency response system.

Training

Administrators. The owner or sponsor of the assisted living program is responsible for ensuring that both management and direct service employees receive training appropriate to the task.

Staff. The assisted living program shall have a training and staffing plan on file and shall maintain documentation of training received by staff. All personnel of the assisted living program shall be able to implement the assisted living program's accident, fire safety, and emergency procedures.

Background Check

Not described.

Monitoring

Monitoring staff hold community meetings with tenants during their site reviews. The meetings often identify concerns about quality and practice for the monitors. A protocol based on the certification requirements is used to guide the review. Tenants, program staff, and family members are interviewed. During the review, rules may be clarified and explained. Monitoring staff often participate in training meetings organized by three associations representing assisted living programs.

Fees

The fee structure was changed in 2004. Distinctions between small and large programs were eliminated. The regulations require a $900 fee for reviewing blue prints. The 2-year initial certification fee is $750. The recertification fee for a nonaccredited program is $1,000 and $125 for an accredited program.

STATE RESIDENTIAL CARE AND ASSISTED LIVING POLICY: 2004

Files Available for This Report

Cover, Table of Contents, and Acknowledgments
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