Iowa Department of Inspections and Appeals
Assisted Living Program
Complaint Investigation Report

Assisted Living Program: **Complaint Intake #**: 7893

Dennis Bock, Administrator
Courtyard Terrace
717 W. 3rd Street
Boone, IA 50036

Date of Monitoring Visit:

June 17, 2004

Monitor(s):

Mary Oliver, LISW

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC – Chapter 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under this chapter 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.

Overview:

A complaint investigation on-site visit was conducted at Courtyard Terrace on June 17, 2004. In preparing this report, the following information was considered:

Current Program Census:

General Population Program -

Current General Population ALP Census: **29** Current number of tenants with dementia: **3 with mild dementia; 0 with GDS 4 or above.**

Complaint History – There were no substantiated complaints this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Occupancy and Transfer Criteria - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3)]

Complaint Allegation: It is alleged that Tenant #1 wandered away from the program and was found disoriented a few blocks away from the building. It is further alleged that the tenant was sunburned upon the tenant's return.

- Investigation Observation: The Tenant Coordinator, Administrator, and Tenant #1 were interviewed. The monitor also reviewed the file, area where the tenant walked and was found, and the area the tenant is now restricted to taking walks. The record revealed that the tenant's functional status, health status, and mental status were assessed before admission in March, reassessed 30 days later, and reassessed after the incident in question. The tenant was found to be independent in eating, transferring, dressing/grooming, bathing, toileting, and ambulation. The tenant showed mild mental impairment on each of the mental status evaluations; however, no staging was done using the Global Deterioration Scale due to high scores on the mini-mental tests given. The nursing record indicated the tenant had some confusion regarding time during the night and the service plan indicated meal reminders should be given. On the day of the monitoring visit, the tenant went to the lunch meal without prompting by staff.

  The tenant was nicely groomed, very pleasant, and well oriented when interviewed. The tenant said a cane was used indoors and a walker was used for longer walks outdoors. The tenant's voice was shaky and the tenant appeared to be somewhat frail. When the tenant was asked if the tenant ever got lost when walking out of doors, the tenant said, "Do you mean really lost? No." The tenant then began to describe the incident that occurred 10 days before on Sunday, June 6. The tenant stated that the tenant walked down past the school and had encountered some mud on the sidewalk so decided to return to the building by walking on the other side of the street. The tenant explained that the street was usually busy but not on Sunday afternoon. The tenant waited for all traffic to be gone, then crossed. The tenant explained that the tenant could easily see the mound of construction dirt just past Courtyard Terrace so the tenant knew the tenant was headed in the right direction. The tenant said the tenant looked up at the street sign but was not at all confused about which way the tenant should be going.

  The tenant said a young woman approached who asked if the tenant was confused and needed help. The tenant said no help was needed. The young woman became quite insistent that the tenant get into her car so she could return the tenant to the program. The tenant complied. The tenant file indicated the tenant was flushed but not sunburned when the tenant returned to the building.

  The intersection the tenant crossed was about one and a half to two blocks from the program; the first intersection encountered after leaving the building. As described by the tenant, there were several benches available along the walkway where the tenant could rest. The sidewalk was somewhat bumpy in various areas. The road was busy during the workday as described by the tenant. The mound of construction dirt was clearly visible from the corner where the tenant crossed and there was another crossing across from the front door of the program building.

  When the tenant was returned to the program, the program notified the tenant's daughters who visited with the tenant and determined that the tenant was not confused and had intentionally crossed the street to avoid some mud on the sidewalk.

- Regulatory Insufficiency: None noted.

B. Assisted Living Definition – Program encourages family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence. [Iowa Code section 231C.2]

During the course of the investigation, it was discovered that administration developed a managed risk agreement with the tenant's daughters and subsequently discussed the agreement with the tenant. The tenant said, when interviewed, that she agreed to go along with the agreement for a while anyway, but she felt like she was grounded. The tenant explained and documentation confirmed that the agreement required the tenant to walk only in the courtyard and gazebo areas of the campus unless a staff or family member accompanied the tenant. The tenant stated that walking as much as possible was necessary to keep the knee prosthesis working properly. Both the courtyard and gazebo areas offered limited distances for the tenant to walk so the tenant said many trips around were necessary to get the amount of exercise needed. The tenant also said that the tenant liked the idea of having someone along when walks were taken because of the fear of falling. Administrative staff indicated they were willing to help the tenant get outside to walk with a staff member on a regular basis.

The tenant was found to be independent in eating, transferring, dressing/grooming, bathing, toileting, and ambulation. The tenant showed minimal cognitive impairment on all three of the mental status evaluations performed prior to and since admission. No staging was done using the Global Deterioration Scale due to high scores on the mini-mental tests given.

- Regulatory Insufficiency: The program did not fully support tenant self-direction and tenant autonomy as referred to in the Code of Iowa.

Dated this 23rd day of June, 2004.