IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

November 24, 2008

Complaint #20713-C

Melissa Sherod, Administrator
3801 Grand Ave
3801 Grand Assisted Living
Des Moines, IA 50312-2800

RE: Complaint Investigation Report, 3801 Grand Assisted Living, Des Moines, IA

Dear Sherod:

Enclosed is the **Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with the Code of Iowa, section 231C.7, Iowa Administrative Code, chapter 25, pertaining to assisted living programs and, chapter 26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

A copy of the monitor's **Complaint Investigation Report** is enclosed for your information and as a record of the result of this investigation.

If you have any questions regarding this Report, please contact me at 515-281-5003

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #:** 20713-C

Melissa Sherod, Administrator
3801 Grand Ave
3801 Grand Assisted Living
Des Moines, IA 50312-2800

Date of Investigation:

November 18, 2008

Monitor(s):

Hal L. Chase, RN BSN MPH

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 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 revisit 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 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 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 3801 Grand Avenue Assisted Living on November 18, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder

Current number of tenants in a DSP that serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	16
Current number of tenants without cognitive disorder	35
Total Population:	51

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There have been no substantiated complaints during this certification period.

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

A. Criteria for exclusion of tenants - 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); 25.24]

Complaint Allegation: It is alleged Tenant #1 wanders into other tenants' rooms, when confronted by staff or tenants' becomes combative and swings at staff and tenants'

- Monitoring Observation: Tenant #1, an 80 year old, was admitted on 9-25-05 and has diagnoses of: Dementia, Hypertension (HTN) and Diabetes Mellitus. A Global Deterioration Scale (GDS) was completed on 9-25-08 and staged the tenant at five which indicated moderately severe cognitive decline. Nurse's notes of 6-30-08 through 11-17-08 indicated one incident, 8-3-08, of marked increase of aggression and combativeness toward staff and tenants. The tenant's physician was contacted on 8-3-08 with the physician ordering Accu-checks four times daily the following day and to report results. The tenant's physician ordered an increase in Seroquel from twice daily to three times daily No other incidents were reported. Staff #1 stated the tenant can be verbally abusive at least weekly but is not known for being physically combative. Staff #2, #3 and #4 did not identify any tenant as being physically or verbally abusive toward tenants or staff.

  The tenant's service plan of 9-25-08 indicated the tenant needed a guide when going outside the program. Staff #1 stated the tenant wandered until he/she was moved to the first floor and continues to wear a Wanderguard. Staff #2 stated the tenant use to wander the halls but has since moved to an apartment downstairs and likes to stay in the lobby. The tenant had never attempted to leave the program. Staff #3 stated the tenant had a history of wandering but has since moved to a downstairs apartment in the last month and hasn't wandered. Staff #4 stated the tenant wanders in the lobby but did not identify the tenant as wandering outside. Iowa Code 231C – Iowa Administrative Code (IAC) Chapter 25 for Assisted Living does not have regulations prohibiting tenants from wandering throughout the program or into other tenants' rooms.

Complaint Allegation: It is alleged Tenant #2 often gets lost and can't find his/her room. The Tenant wears a Wanderguard but only the front door is alarmed and the Tenant goes out the second floor of the building. Not long ago the Tenant was found lost in the parking garage.

Monitoring Observation: Tenant #2, a 94 year old, was admitted on 3-28-05 and has diagnoses of: Dementia, Depression, Osteoporosis and Vitamin B-12 Deficiency A GDS was completed on 3-25-08 and staged the tenant at five which indicated moderately severe cognitive decline. Service plan of 3-25-08 indicated the tenant was alert to self and routines, but at times needs prompting to meals and activities. Nurse's notes of 5-5-08 through 11-10-08 did not indicate getting lost or eloping out of the building. Staff #1 stated the tenant had worn a Wanderguard for about a month, but the family requested its removal and the tenant is not considered a "flight risk." Staff #2, #3 and #4 did not identify the tenant as wandering out of the program. Iowa Code 231C – Iowa Administrative Code (IAC) Chapter 25 for Assisted Living does not have regulations prohibiting tenants from wandering throughout the program or into other tenants' rooms.

Complaint Allegation: It is alleged Tenant #3 falls often and it takes two staff to lift the tenant.

- Monitoring Observation: Tenant #3, an 82 year old, was admitted on 8-16-08 and has diagnoses of: Acute Bronchitis, Acute Sinusitis, Dementia, Chronic Constipation, Essential HTN, Hyperlipidemia, Hypothyroidism, Insomnia, Osteoarthritis and History of Pneumonia. A GDS was completed on 9-16-08 and staged the tenant at five which indicated moderately severe cognitive decline. Incident reports of 9-4-08 through 11-16-08 indicated at least seven falls, but did not indicate the need for two staff to lift the tenant off of the floor. Functional and health evaluations of 9-16-08 and service plan of 9-16-08 indicated the tenant needed "guide" assistance with mobility and transfer but did not indicate the tenant needed routine two person assistance with ambulation and transfer. Staff #1, #2, #3 and #4 identified the tenant as falling but not needing routine two person assistance with transfer, ambulation or evacuation.

Complaint Allegation: It is alleged Tenant #4 is a two person transfer with all transfers, including toileting, bed to chair, chair to wheelchair and the tenant is unable to transfer by himself/herself.

- Monitoring Observation: Tenant #4, an 83 year old, was admitted on 9-18-06 and has diagnoses of: Parkinson's Disease. Functional and health evaluations of 9-18-08 and service plan of 9-18-08 indicated the tenant needed assistance of one with ambulation and transfer Staff #1, #2, #3 and #4 stated the tenant needed the assistance of one staff for ambulation and transfer. Physical therapy evaluation and treatment of 11-13-08 indicated the tenant was successful with physical therapy and needed the assistance of one staff with ambulation and transfer.

- Regulatory Insufficiency: None noted.

B. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It is alleged staff do not have gait belts when Tenant #4 needs assistance with all transfers.

- Monitoring Observation: Staff #1, #2, #3 and #4 stated the tenant was a routine assistance of one staff with ambulation and transfer. Physical Therapy evaluation and treatment indicated the tenant was a one person assist with ambulation and transfer. Staff #1 stated she thought the use of gait belts were prohibited in assisted living programs, so the program did not have gait belts. Staff #2, #3 and #4 stated they did not use gait belts. The program stated they did not use gait belts.

- Regulatory Insufficiency: None noted.

Dated this 24th day of November, 2008.