IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake: 29108-C

September 14, 2010

Ms. Joni Fahrenkrog, Administrator
Grand Haven Assisted Living
201 East Franklin Street
Eldridge, IA 52748

RE: Final Complaint Investigation Report – Grand Haven Assisted Living, Eldridge, IA

Dear Ms. Fahrenkrog:

Enclosed is the **Final Complaint Investigation Report** from the on-site monitoring visit of August 17, 2010, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #: 29108-C**

Ms. Joni Fahrenkrog, Administrator
Grand Haven Assisted Living
201 East Franklin Street
Eldridge, IA 52748

Date of Complaint Investigation:

August 17, 2010

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. IAC r. 481-67.10(5). 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 an Incident 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 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Grand Haven Assisted Living on August 17, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	63
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	66

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	10

Total Census of ALP: 76

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

Program History – There were no Regulatory Insufficiencies found during this on-site inspection.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Occupancy Agreement

Complaint Allegation #29108-C: It is alleged a tenant paid for additional services of bathing, medication administration and transportation to meals. The tenant was hospitalized on 4-9-10. On 4-13-10 a family member notified the program the tenant would not be returning to the program. A request was made for a refund for the additional services the tenant did not use for the month of April, 2010.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1, a 102 year old, was admitted on 8-7-08 and had diagnoses of: Macular Degeneration, Hiatal Hernia, Hard of Hearing, History of a Fractured Femur and a History of Coronary Artery Bypass Graft. A cognitive evaluation was completed on 9-12-09 and staged the tenant at four on the GDS which indicated moderate cognitive decline. The tenant resided in the general population. A service plan of 9-12-09 indicated the tenant received assistance with eating, bathing, dressing and medication administration. The tenant was independent with the use of a walker and staff were to use a wheelchair when transferring the tenant to and from the dining room.

  Program records indicated the program's occupancy agreement indicated both the program and the tenant or tenant's legal representative have the right to terminate the agreement; by providing a 30-day written notice to the program's manager of such intent to terminate, on or before the first of the last month of residency. The occupancy agreement included services the tenant may enter into an agreement to receive.

- Regulatory Insufficiency: None noted.

B. Other

Complaint Allegation #29108-C: It is alleged a tenant fell at 2:30 a.m. on 4-8-10. The program reported the fall at 8:00 a.m. to a family member who was not the tenant's Power of Attorney. On 4-16-10, the program notified family the tenant needed to go to the hospital for evaluation. When asked by family which hospital the tenant would be transported to, the program indicated the ambulance crew would decide. It is alleged the tenant left the program at 5:00 p.m. At 6:15 p.m. the family called the program and was told which hospital the tenant was transported. A hospital physician asked how many falls the tenant had had and was told the tenant had three falls in a three week period. The hospital physician indicated the tenant could not return to the program and the tenant was transferred to a nursing facility.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1's file indicated the tenant had a power of attorney but did not have a medical power of attorney. On 12-3-09 the tenant's physician indicated due to the tenant's GDS of four he/she lacked the capacity to make medical decisions and recommended a Durable Power of Attorney (DPOA) be activated. A review of the tenant's file indicated a DPOA was not activated. The tenant was found on the floor three times between 2-6-10 and 4-8-10. The current service plan of 9-12-09 indicated the tenant had a history of falls, was independent with ambulation with the use of a walker and staff was to use a wheelchair when transferring/transporting the tenant to and from the dining room.

Incident report of 2-6-10 indicated the tenant had paged for assistance and staff found the tenant on the floor with his/her pants and incontinent undergarments pulled down. Nurse's notes of 2-6-10 indicated the program's Registered Nurse (RN) completed a nurse review and indicated the tenant had reported trying to go the bathroom. The RN indicated there was no change in the tenant's functional, cognitive and health status. Incident report of 2-27-10 indicated the tenant paged for assistance and staff found the tenant on the floor. Nurse's notes of 2-27-10 indicated the program RN completed a nurse review and notified the tenant's physician of finding the tenant on the floor. A 90-day nurse review was completed and indicated no changes the tenant's functional, cognitive and health status.

An incident report of 4-8-10 indicated staff found the tenant lying by the bed with a large skin tear on the right leg and right forearm. Nurse's notes of 4-8-10 indicated the tenant fell at 2:15 a.m. in his/her apartment and sustained a skin tear to the right arm and right leg and a bruise to the right breast area four centimeters in length. The family was notified at 8:00 a.m. and the program was awaiting orders from the tenant's physician. Program records indicated the tenant's physician was notified of the tenant's injuries. The tenant's physician wrote an order to treat the tenant's wounds with antibiotic ointment, to change the dressing daily and watch for infection. Nurse's notes of 4-9-10 indicated the program RN completed a nurse review and a physician's order indicated the program was to apply triple antibiotic ointment and dry dressing changes daily. Nurse's notes of the same day, but a separate entry, indicated the program RN completed a nurse review as the tenant was complaining of right sided pain. The tenant's family was notified and agreed to have the tenant evaluated and transported the tenant to local hospital emergency room. Nurse's notes of 4-13-10 indicated the tenant's family member notified the program the tenant would be moving out of the program and into a nursing facility.

Three staff and the program RN were interviewed. Staff #1 stated the tenant did not have a history of falls but may have had a couple of falls in the past year. She stated the tenant's skin was thin and the tenant has had skin tears on his/her arm. Staff was to use a wheelchair to transport the tenant to meals and activities. The tenant was cognitive and could use the call pendant for assistance. The tenant was independent with ambulation inside his/her apartment. Staff #1 stated she remembered the tenant had fallen but didn't remember the details of the fall. Staff #2 stated she was aware of the services the tenant needed. The tenant needed assistance with dressing, showers and needed to be escorted to meals and activities. The tenant called for assistance with toileting. The tenant did not have a history of falls. More times than not, the tenant was confused. The tenant could make his/her own decisions but he/she could not see very well as the tenant had poor eyesight. Staff #2 stated the tenant would get out of his/her wheelchair and would hit his/her arm and leg and would have skin tears. The tenant was stubborn and would do things on his/her own though he/she knew better. Staff #3 stated the tenant needed assistance with bathing and was transported by wheelchair to meals and activities but was independent with ambulation in his/her apartment. The tenant was alert and oriented to person and place but not to time. The tenant could express his/her needs, used the call pendant and tried to be as independent as possible. The program RN stated the tenant did not have a history of falls. Staff did provide ambulation assistance when the tenant was outside his/her apartment, to the dining room and activities. The tenant had fallen and

had a skin tear to the right leg and possibly the right arm sometime on the third shift on 4-8-10. Later that morning, the RN checked the wound care given by night staff. She called the tenant's physician for instructions. The tenant's service plan was reflective to the tenant's needs and was appropriate to live at the program.

- Regulatory Insufficiency: None noted.

Dated this 3rd day of September, 2010.