

INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 37788-I

March 22, 2012

Ms. Kathy Shriner, Director
Calvin Community AL Services
4210 Hickman Road
Des Moines, IA 50310

**RE: Final Complaint/Incident Investigation Report – Calvin Community
Assisted Living, Des Moines, IA**

Dear Ms. Shriner:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 19, 2012, 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/Incident Investigation Report

Assisted Living Program:

Kathy Shriner, Director
Calvin Community AL Services
4210 Hickman Road
Des Moines, IA 50310

Complaint/Incident Intake #:

#37788-I

Date of Complaint/Incident Investigation:

March 19, 2012

Monitor(s):

Joyce Kix, RN
Maribeth Freland, RN

Definitions: *The following definitions are relevant:*

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: *In preparing this report, the following information was considered:*

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	58
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	63
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	13
TOTAL census of Assisted Living Program	76

Program History – The program did not receive any regulatory insufficiencies during this certification period.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Other

Complaint/Incident Allegation: The program reported that a tenant alleged another tenant had poked him/her with a cane, knocked on his/her apartment door in the early morning hours and at some time in the past hit him/her with a two by four piece of wood.

- **Monitoring Observation:** The monitors reviewed the clinical records of the two tenants involved in the reported incident. Both tenants experienced mild cognitive deficits and resided on the same general population floor of the assisted living. Tenant #1 had a history of teasing staff members and other tenants verbally and occasionally lifted his/her cane toward others in a joking manner. Tenant #2 reported Tenant #1 teased and poked at him/her with his/her cane on 1-25-12. Following report of this incident, Tenant #2 began to report differing allegations: including Tenant #1 striking him/her with a wooden fruit crate which later was reported to be a two by four piece of wood while Tenant #2 stood at the elevator, causing Tenant #2 to fall back into passengers on the elevator thereby avoiding a fall (Tenant #2 varied his/her reports to include bruising to the entire body with questionable bone fractures); Tenant #1 knocking on Tenant #2's apartment door in an attempt to bother him/her; and Tenant #1 frequently hid in a trash room in an attempt to stalk Tenant #2.

Tenant #2 reported the incident involving the two by four was witnessed by multiple staff members and tenants. The program was unable to confirm the existence of a wooden fruit crate or a two by four section of wood. The program interviewed all staff members about the alleged incident, finding no witnesses to the incident. The program interviewed the tenant identified by Tenant #2 as being present during the alleged incident. This tenant reported seeing no aggression by Tenant #1; however, he/she observed Tenant #2 kick Tenant #1 in the shin. Tenant #2 had no documented injuries, bruising or fractures that could be attributed to the alleged incident.

After Tenant #2's allegations that Tenant #1 knocked repeatedly on his/her apartment door, the program initiated twice nightly safety checks on Tenant #1, routinely finding him/her asleep in bed. The program staff members denied ever observing Tenant #1 hiding in the general trash room area. Staff members denied observing any inappropriate interactions between Tenant #1 and Tenant #2 after the initial reported incident of Tenant #1 jokingly poking at Tenant #2 with his/her cane.

The monitors interviewed Tenant #2 who did not report any concerns with his/her door being knocked on during the night. Tenant #2 did report Tenant #1 once hit him/her on the shoulder with a two by four piece of wood while awaiting the arrival of an elevator. Tenant #2 reported it hurt when he/she was hit but denied any injury from this alleged incident. Tenant #2 denied kicking Tenant #1. Tenant #2 reported being scared following this incident; however, denied any further incidents involving Tenant #1. Tenant #2 reported Tenant #1 occasionally stares at him/her but had not attempted any other physical aggression. Tenant #2 reported he/she no longer feared Tenant #1 and did not believe Tenant #1 would attempt to harm him/her.

The monitors observed Tenant #1 sitting on a loveseat calmly conversing with a female tenant. Both tenants were laughing and appeared to be in friendly conversation. The monitors later observed Tenant #1 eating at a dining room table with two male tenants calmly conversing and joking with each other.

The monitors were unable to find substantial evidence that Tenant #2 had been hit by Tenant #1 with a fruit crate or with a two by four piece of wood. The monitors identified no injuries to Tenant #2 that could be attributed to the alleged incident. The program put procedures in place to monitor Tenant #1's whereabouts at night, finding no evidence of his/her knocking on Tenant #2's apartment door. The program staff members had never observed Tenant #1 hiding in the general trash room area.

- Regulatory Insufficiency: None noted.