

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0442	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/06/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRAND LIVING AT TOWER PLACE AL

**540 S 51ST STREET
WEST DES MOINES, IA 50265**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 130 Number of tenants with cognitive impairment: 4 Total census: 134 The following regulatory insufficiencies were cited during the investigation of Complaint #125362-C.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure adequate and appropriate services were provided for 1 of 3 tenants reviewed in specific (Tenant 1) as well as an unspecified number of other tenants of the program (total census 134). Findings follow: Record review on 1/27/25 revealed Tenant 1 admitted to the program on 7/29/2021 with diagnoses including paraplegia, hyperlipidemia, and other chronic pain. A service plan dated	A 160	In accordance to regulation 481-67.3(2) Tenant Rights 481-67.3 Tenant Rights. All tenant have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. Meeting scheduled for 4/2 to review Notify Call Light System and review call light time expectations. National staffing recruiter notified of staffing needs. Health and Wellness team to monitor staff to ensure they are logged into notify and that the phone volume is on.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 160	Continued From page 1 6/20/24 revealed Tenant 1 required staff assistance of one with bathing, dressing including TED hose, transfers, and toileting. Notes under toileting on the service plan indicated the tenant paged if she needed assistance. Unlicensed personnel were to physically assist the tenant to use the toilet, and/or change undergarments and provide pericare as needed. The service plan indicated the tenant may require transfer assistance during the task of toileting. Tenant 1 was provided PT/OT (physical therapy/occupational therapy) services with an outside provider agency. The service plan further instructed staff to conduct a well-being check daily mid-morning. Further review of service plans dated 10/1/24 and 12/19/24 confirmed Tenant 1 maintained the same needs for the toileting task. During an interview with Tenant 1 on 2/4/25 at 1:00 pm, she stated concerns with her call light not being answered in a timely manner. There were times when she would attempt to self-transfer and get herself caught "dangling" between her wheelchair and the toilet or be left in soiled undergarments. Tenant 1 stated 8/23/24-8/24/24, 11/7/24-11/8/24, 12/24/24, 1/22/25 were some of the dates she recalled experiencing issues with staff not responding timely to call lights. During an interview on 1/27/25 at 4:00 pm Staff A stated she regularly worked 2nd shift (PM) and she and another staff member were responsible for administering medications and providing cares for the assisted living residents that lived on floors 2, 3 and 4. She described the workload as "not bad," but it could get busy during meal times when all the tenants wanted to go to the dining room, or on the weekends at times.	A 160			

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A 160	Continued From page 2 During an interview on 1/28/25 at 11:15 am, Staff B confirmed the assistants were responsible for providing cares and passing medications. She stated there was regularly two staff working on the 1st shift (AM) and stated the program had been trying to schedule a 3rd assistant to work the shift as well who would be responsible for showers while the other two assistants focused on the other cares and medications. She felt that both AM and PM shifts seemed to be good currently and didn't feel that tenants had concerns with call light response times. On 1/28/25 a review of Call Light Reports revealed the following: - From 8/23/24 to 8/24/24, Tenant 1 had 3 call lights responded to after 19 minutes. On 8/23/24, there were 6 call lights from other tenants from floors 2-4 with call lights responded to between a range of 17 to 106 minutes. On 8/24/24, there were 15 call lights from other tenants from floors 2-4 with call lights responded to between a range of 15-26 minutes. - From 11/7/24 to 11/8/24, Tenant 1 had 2 call lights responded to after 24 minutes. On 11/7/24, there were 11 call lights from other tenants from floors 2-4 with call lights responded to between a range of 16-35 minutes. On 11/8/24, there were 15 call lights from other tenants from floors 2-4 with call lights responded to between a range of 15-63 minutes. - On 12/24/25, there were 10 call lights from other tenants from floors 2-4 with call lights responded to between a range of 15-33 minutes. - On 1/22/25, Tenant 1 had 1 call light responded to after 53 minutes. There were 11 call lights from other tenants from floors responded to between a range of 15-97 minutes. During an interview on 1/28/25 at 1:36 pm, the	A 160		

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A 160	Continued From page 3 Director of Health and Wellness (DHW) stated the company expectation and her personal expectation for program staff was to respond to call lights in 8 minutes or less. She stated the program had gone through a "hiccup phase" with staffing in early December 2024 but she, the Assistant Director of Health and Wellness, and Health and Wellness Administrative Assistant regularly helped to cover the floor. On 2/6/25 at 10:55 am the Executive Director and DHW confirmed the above findings.	A 160		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete thorough evaluations for 1 of 1 tenants reviewed who experienced a significant change (Tenant #1). Findings include:	A 145	In accordance to regulation 481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human services professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	

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A 145	Continued From page 4 During an interview on 2/4/25 at 1:00 pm Tenant 1 stated she was hospitalized in August of 2024 due to a wound on the bottom of her right pinky toe. She stated the wound had started as a callus on the bottom of the toe and she had "picked" at it in an attempt to remove it in July of 2024. The area then developed into a wound over the course of about four weeks and her foot eventually became four times bigger than the other. She went to urgent care who prescribed Cephalexin as an antibiotic. She stated urgent care suggested she be seen by a wound care specialist. She went to the wound care specialist on 8/14/24 and was sent from the appointment to the hospital emergency room. She was hospitalized due to the infection in the toe, which resulted in a toe amputation on 8/21/24. She returned to the program on 8/23/24. Tenant 1 stated she was not to bear any weight on the foot for three weeks after the toe amputation and required an assist of two staff for transfers. Further record review on 1/30/25 revealed an assessment with an effective date of 8/23/24. The reason for the assessment was listed as "change of condition: return from hospital" and was completed by the Assistant Director of Health and Wellness (ADHW). The assessment revealed Tenant 1 had a change in staff assistance and now required physical assistance of 2 staff for transfers, but lacked any information regarding Tenant 1's wound and subsequent toe amputation. A section of the assessment entitled "Medical History" instructed the ADHW to "indicate any significant medical concerns the resident has experienced since the last assessment." The ADHW indicated "Not Applicable (N/A)" on the assessment. The section of the assessment entitled "Special Needs"	A 145	Reviewed rules and regulations regarding evaluation of residents and making sure that ADOHW reads and goes through every question very thoroughly. Also, I gave him a copy of of the diagram that shows him if it is just a nursing note vs a nurse review vs evaluation and if service plan needs to be updated. DOHW is continuing to review charts, assessments and service plans to ensure they are done correctly while continuing to train ADOHW.	

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A 145	Continued From page 5 instructed the ADHW to "indicate level of assistance needed with wound care." The ADHW indicated "Not Applicable (N/A)" on the assessment. During an interview on 2/4/25 at 2:50 pm, the DHW confirmed the change of condition assessment on 8/23/24 lacked identification and status of the wound and resulting toe amputation and stated the correct protocol would have been to address these in the wound section of the assessment. On 2/6/25 at 10:55 am the Executive Director and DHW confirmed the above findings.	A 145		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update service plans after a significant change for 1 of 1 tenants reviewed (Tenant 1). Findings follow: Record review on 1/27/25 revealed Tenant 1 admitted to the program on 7/29/21 with diagnoses including paraplegia, hyperlipidemia, and other chronic pain. A service plan dated	A 360	In accordance on regulation 481.69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health related care, the service plan, shall be updated within 30 days of the tenants occupancy and as needed with significant change, but no less than annually. Reviewed rules and regulations regarding service plans and making sure that he reads and goes through every question very thoroughly. He was educated to be very detailed when writing service plans to include all needs and health changes. Also, I gave him a copy of of the diagram that shows him if it is just a nursing note vs a nurse review vs evaluation and if service plan needs to be updated. DOHW is continuing to review charts, assessments and service plans to ensure they are done correctly while continuing to train ADOHW.	

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A 360	Continued From page 6 6/20/24 revealed Tenant 1 required staff assistance of one with bathing, dressing including TED hose, transfers, and toileting. Tenant 1 was provided PT/OT (physical therapy/occupational therapy) services with an outside provider agency. The service plan further instructed staff to conduct a well-being check daily mid-morning. During an interview on 2/4/25 at 1:00 pm Tenant 1 stated she was hospitalized in August of 2024 due to a wound on the bottom of her right pinky toe. She stated the wound had started as a callus on the bottom of the toe and she had "picked" at it in an attempt to remove it in July of 2024. The area then developed into a wound over the course of about four weeks and her foot eventually became four times bigger than the other. She went to urgent care who prescribed Cephalexin as an antibiotic. She stated urgent care suggested she be seen by a wound care specialist. She went to the wound care specialist on 8/14/24 and was sent from the appointment to the hospital emergency room. She was hospitalized due to the infection in the toe, which resulted in a toe amputation on 8/21/24. She returned to the program on 8/23/24. Tenant 1 stated she was not to bear any weight on the foot for three weeks after the toe amputation and required an assist of two staff for transfers. Further review on 1/30/25 revealed an assessment with an effective date of 8/23/24. The reason for the assessment was listed as "change of condition: return from hospital" and was completed by the Assistant Director of Health and Wellness (ADHW). The assessment revealed Tenant 1 had a change in staff assistance and now required physical assistance of 2 staff for transfers. The ADHW did not update the service plan following the change of condition	A 360			

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A 360	Continued From page 7 assessment to reflect the change in assistance level for transfers, the toe amputation and the need to not bear weight for 3 weeks on the affected foot as noted by the tenant. During an interview on 2/4/25 at 2:50 pm, the DHW confirmed the change of condition assessment on 8/23/24 lacked identification and status of the wound and resulting toe amputation and stated the correct protocol would have been to address these in the wound section of the assessment and to update the service plan. On 2/6/25 at 10:55 am the Executive Director and DHW confirmed the above findings.	A 360		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete a nurse review upon a change in health status for 1 of 1 tenants reviewed who had a foot wound and subsequent toe amputation (Tenant 1). Findings follow:	A 430	In accordance to regulation 481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receive personal or health related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status.	

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A 430	Continued From page 8 During an interview on 2/4/25 at 1 pm Tenant 1 stated she was hospitalized in August of 2024 due to a wound on the bottom of her right pinky toe. She stated the wound had started as a callus on the bottom of the toe and she had "picked" at it in an attempt to remove it in July of 2024. The area then developed into a wound over the course of about four weeks and her foot eventually became four times bigger than the other. She was hospitalized due to the infection in the toe, which resulted in a toe amputation on 8/21/24. She returned to the program on 8/23/24. Tenant 1 stated she was not to bear any weight on the foot for three weeks after the toe amputation and required an assist of two staff for transfers. Further review on 1/30/25 revealed an assessment with an effective date of 8/23/24. The reason for the assessment was listed as "change of condition: return from hospital" and was completed by the Assistant Director of Health and Wellness (ADHW). The assessment revealed Tenant 1 had a change in staff assistance required, and now required physical assistance of 2 staff, but lacked any information regarding Tenant 1's wound and subsequent toe amputation. A section of the assessment entitled "Medical History" instructed the ADHW to "indicate any significant medical concerns the resident has experienced since the last assessment." The ADHW indicated "Not Applicable (N/A)" on the assessment. The section of the assessment entitled "Special Needs" instructed the ADHW to "indicate level of assistance needed with wound care." The ADHW indicated "Not Applicable (N/A)" on the assessment.	A 430	Reviewed rules and regulations regarding service plans and making sure that ADHOW reads and goes through every question very thoroughly. He was educated to be very detailed when writing service plans to include all needs and health changes. Also, I gave him a copy of of the diagram that shows him if it is just a nursing note vs a nurse review vs evaluation and if service plan needs to be updated. DOHW is continuing to review charts, assessments and service plans to ensure they are done correctly while continuing to train ADOHW.	

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A 430	Continued From page 9 During an interview on 2/4/25 at 2:50 pm, the DHW stated the program used the full assessment form instead of a separate nurse review form. She confirmed the change of condition assessment on 8/23/24 lacked identification and status of the wound and subsequent toe amputation. On 2/6/25 at 10:55 am the Executive Director and DHW confirmed the above findings.	A 430			