Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date:	January 10, 2020
Program Name:	Legacy Gardens
Address:	15 Silvercrest Place Iowa City, IA 52240
Type of Action:	Investigation #86500-I
Date(s) of Action:	12/3/19 – 12/5/19

State Rule #	State Rule	Amount of Civil Penalty
481-67.3(2)	**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.** Based on interview and record review the Program failed to provide adequate and appropriate services to meet the identified needs of tenants. This pertained to 1 of 1 tenant reviewed that eloped (Tenant #1) and potentially affected all tenants (census of 23). Findings follow: 1. Record review of a Tenant/Resident Incident Report reflected on 9-13-19 at 6:30 p.m. Tenant #1 eloped. There were no injuries noted. The Assistant Director of Nursing (ADON) was notified and family was notified. Charting Notes dated 9-16-19 (completed by the ADON) reflected the ADON received a telephone call on 9-13-19 at 9:00 p.m. from staff regarding Tenant #1 leaving the building unattended at approximately 6:30 p.m. The front entrance was checked, the outside of the building was checked and a head count was started. When the head count was being completed a staff from the independent living (IL) building brought Tenant #1 back to the building at approximately 7:00 p.m. The Executive Director (ED) and Regional Director of Nursing were notified. The ADON came to the building and completed an assessment. Tenant #1 was calm, showed no signs of distress and had no recollection of going for a walk outside of the building. There was no visible injuries noted, Tenant #1 denied pain and was able to bear full weight. An Incident Investigation Report dated 9-16-19 reflected on 9-13-19 the front lobby door went off. Staff did not respond immediately because they were helping another tenant and could not leave them unattended. Staff responded to the alarm when finished and looked outside for any unattended tenants and did not see anyone. A head count was initiated and during the process a staff from independent living (IL) brought Tenant #1 back to the building. An IL resident had seen her outside of her window. The investigative conclusion indicated staff did not respond to the door alarms per policy and Tenant #1 left the locked unit and was brought back unharmed. Tenant #1 eloped from the building. Corrective action was noted as required and indicated all staff would be re-educated on the policy and procedure for door alarms and elopements.	**$2500.00**

	An untitled and undated Program document indicated on 9-13-19 the ADON was notified Tenant #1 eloped. At 6:37 p.m. the front lobby entrance door alarm went off. There were four staff working at the time of the incident, one Program staff and three agency staff. When the pager alarmed Staff A was assisting another tenant and was unable to leave the other tenant unattended. When Staff A finished assisting the other tenant she went to the lobby door at approximately 6:58 p.m. She went outside and looked for any unattended tenants and did not see anyone. She then came back inside and started a head count. During the time of the head count an IL staff brought Tenant #1 back to the building and said another tenant had seen her outside. Tenant #1 was dressed appropriately for the weather. Tenant #1 had previously lived in the IL with her spouse who still resided there. Tenant #1 had lived at the Program since March 2019. When assessed on 9-13-19 there were no issues or concerns noted. Family, the physician and the nurse on-call were notified. Staff was re-educated on the tenant missing persons/elopement policy and the door alarm policy. Staff was aware door alarms must be responded to immediately. The Director of Nursing (DON) and ADON inquired as to why walkie-talkies were not carried and staff was re-educated on usage. Elopement drills were to be done randomly for continuous education and preparedness for staff. Staff A's (Program staff) statement indicated after the evening meal at approximately 7:00 p.m. she finished up a task with another tenant when when she received a page for the front door alarm. When she was done assisting the other tenant she went to check the door alarm. She checked outside and did not see anyone. She returned back inside and started a head count. When she was completing the head count someone from the IL brought Tenant #1 back. The statement indicated she was gone for 30 minutes at most. Regarding the weather, it was light outside and approximately 70 degrees. Tenant #1 was wearing an orange shirt with a yellow sweater, gray sweatpants and brown shoes. There were no injuries noted. Once Tenant #1 was brought back she still tried to leave. There were a couple of people watching her until she was in bed. Staff B's (IL staff) statement indicated it was about 6:30 p.m. to 7:00 p.m. she got telephone call from a IL resident who said a woman walked outside the sliding glass door and she was unsure where she lived. Staff B responded to the IL apartment and a woman (Tenant #1) repeated an address and said she was unsure where she lived. The IL resident thought Tenant #1 looked familiar and they learned who her spouse was and Tenant #1's last name. Staff B walked Tenant #1 back to the Program. When they got back Staff B talked to one of the staff about what happened and she was physically upset and went around talking about what happened. When she got back to the IL she let the IL resident know that Tenant #1 made it back safely. She also told Tenant #1's spouse what had happened. Staff C's (agency staff) statement indicated at approximately 6:45 p.m. an alarm sounded at the front door. Staff A said she had checked the doors and did a head count. An agency staff on the other side of the hallway said she also checked the door that alarmed. Within 10 to 15	

	minutes Tenant #1 was returned from the IL building to the Program by staff. There were no injuries noted and Tenant #1 denied pain/discomfort. 2. When interviewed on 12-3-19 at 3:03 p.m. Staff A revealed she was working on second shift and was working with agency staff. She was giving another tenant a bath in the bathing room. She thought it was about 7:00 p.m. and her pager went off and she could not look at it right away. Once she could look at it she saw it was the front door going off. She went to check on the front door and went outside to look. Her pager was still going off when she responded to the door. Agency staff told her IL staff had brought Tenant #1 back from the IL building. She checked everyone to make sure all tenants were accounted for and all tenants were present. She checked on Tenant #1 and she was irritated but did not have any injuries. Tenant #1 had on sweatpants, shoes, a shirt and sweater. Tenant #1 ambulated independently. Regarding the weather, it was warm, it was still light out and there was no precipitation. Tenant #1 was last seen by Staff A in the living room watching television at approximately 6:30 p.m. When Tenant #1 returned to the building she kept trying to leave and wanted to see her spouse. Someone had watched until bed approximately 9:30 p.m. Tenant #1 filled out an incident report and said she had not completed an incident report before. Staff did not use walkie-talkies and they were available for use. That night the ADON came in and did an elopement drill. When interviewed on 12-4-19 at 9:07 a.m. the ADON revealed she received a telephone call at approximately 9:00 p.m. from Staff A. She was told the door alarms had gone off and Staff A was assisting another tenant with cares. She responded to the door alarm and looked outside and did not see anyone. A head count was started and IL staff had brought Tenant #1 back to the building. Tenant #1 had appropriate clothing, no complaints of pain and no visible injury. The ADON said the ED and Regional Director of Nursing were notified. The ADON revealed Staff A did not understand she needed to call as there were no injuries to Tenant #1. The more Staff A thought about it she then called the ADON. The ADON came into the building at approximately 10:00 p.m./10:30 p.m. (close to shift change) and completed an assessment of Tenant #1, which did not reveal any injuries or complaints of pain. Tenant #1 was lying in bed and was surprised to see the ADON. Tenant #1 was not in distress and did not have any recollection of the incident. After the assessment she discussed the situation with staff and went over the proper steps. The physician was notified on 9-16-19, a voicemail was left for family and staff was asked to write statements. The ADON said Tenant #1 was last seen at the evening meal, which was at 5:00 p.m. It was determined Staff A said the front door alarmed (it went off at 6:37 p.m. and was reset at 6:58 p.m.). When the ADON arrived staff had pagers and she thought Staff A said she did not have a walkie-talkie (although available to her). When the door alarms went off staff was expected to respond and expected to radio. Regarding the incomplete safety checks the ADON said she believed staff completed the checks; however, did not document them. There	

	were four or five staff working including, one Program staff and the rest agency staff. They liked staff to respond as quickly as possible to the door alarms. Regarding training for agency staff on the door alarms, walkie-talkies and policies there was no documented training. Agency staff were walked around the building, shown how to reset the alarm and shown the pagers and walkie-talkies. The door alarm would alarm for a time period and the pager would continue to go off. There was re-education for staff on the communication with the walkie-talkies and to notify the nurse on-call as soon as anything happened. When interviewed on 12-4-19 at 10:05 a.m. the DON revealed on the Monday following the incident an investigation was started. Staff statements were collected. It was determined an alarm went off at 6:37 p.m. for the front entrance door. Staff A could not leave as she was assisting another tenant with a bath and could not leave that tenant. There was one Program staff and the remaining staff were agency staff. When Staff A responded to the door it was still green (unlocked). The pager would keep beeping until it was cleared. Staff A started a head count and an IL staff brought Tenant #1 back to the building. Tenant #1 had appropriate clothing on and was not in distress. Tenant #1 had been last seen after the evening meal and it was served between 5:00 p.m./5:30 p.m. Staff A was a new employee and had unaware of the process and did not realize she needed to the call the on-call nurse. The ADON assessed Tenant #1 and she had no recollection of the incident and no injuries. He was not sure if Staff A or agency staff knew of the expectation to carry walkie talkies. All staff had a pager. The DON revealed he felt staff completed the safety checks; however, they were not documented. Agency staff were trained verbally however, there was not a hard copy of the training for agency staff. Program staff had access to all policies and during the orientation process staff had training. There was a delay in responding to the door alarms, staff did not have walkie-talkies and there was an expectation to notify the nurse on-call. When interviewed on 12-4-19 at 10:53 a.m. the ED reveled she was notified that evening right after the ADON received a telephone call. She was told Tenant #1 had gone to the IL, where her spouse lived and where she used to reside. The Regional Director of Nursing was also notified. An investigation and attempts to report to the Department started on the following Monday. For corrective action the Program needed to increase the frequency of elopement drills, a focus on training/hiring staff to limit the use of agency staff and all staff had signed off on the policy and procedure (regarding door alarms and elopement). 3. Continued record review of Tenant #1's file revealed a diagnosis that included: Alzheimer's dementia. Tenant #1 was staged at a Global Deterioration Scale (GDS) of four, which indicated moderate cognitive decline. The service plan dated 4-8-19 (service plan in place at the time of the incident) reflected Tenant #1 had a history of exit seeking in her apartment in the IL. Staff was to try to redirect Tenant #1 by offering to spend time on a 1:1 activity, offering a snack or beverage or walking or exercising with Tenant #1. If it was not effective to notify the nurse. It also indicated Tenant #1 had shown	

	impaired judgement to her spouse by trying to leave the apartment at inappropriate times or when she believed something was going on that was not actually happening. Tenant #1's service plan dated 4-8-19 reflected safety checks every hour during the day and every 30 minutes at night. The September medication administration records (MARs) reflected Seroquel 25 milligram tablet, take one tablet every day as needed for agitation. On 9-13-19 at 9:00 p.m. it was charted as administered as needed and the result was indicated as not effective. Tenant #1's service plan dated 4-8-19 and 9-18-19 reflected safety checks every hour during the day and every 30 minutes at night. An ADL Worksheet from safety checks for the entire side of the building that Tenant #1 resided reflected the last safety check on 9-13-19 that was documented as completed was at 6:00 a.m. There were no additional safety checks documented from 6:30 a.m. to 11:30 p.m., including prior to and after Tenant #1's elopement. Further record review of door alarm records indicated the lobby entrance door alarmed on 9-13-19 at 6:37 p.m. and it was reset 21 minutes and 5 seconds later at 6:58:14 p.m. Prior to the 9-13-19 6:58:14 p.m. alarm clear on 9-13-19 at 6:56:26 p.m. the front door bell went off and was cleared at 6:58 p.m. A schedule document indicated on 9-13-19 on second shift five staff were scheduled, Staff A and four staff from two different staffing agencies. Training records prior to the incident with Tenant #1, for agency staff for the door alarms, walkie talkies and missing tenant policy were requested and were not available. The State Climatologist revealed the following weather conditions on 9-13-19 at 6:00 p.m.: temperature was 67 degrees, relative humidity was 68% and winds were from the southwest at five miles per hour (mph). There was no cloud cover, no precipitation and no heat index. On 9-13-19 at 7:00 p.m. weather conditions were: temperature was 64 degrees, relative humidity was 73% and winds were calm. There were clear conditions. Tenant #1's elopement was not witnessed and the exact path Tenant #1 traveled could not be determined; however, when observed on 12-3-19 at approximately 4:25 p.m., possible terrain traveled included: parking lots, sidewalks and grassy area. When the monitor traveled by foot from the Program's entrance to the independent living building it took approximately 2 minutes and 30 seconds. 4. Continued record review revealed the Program's Tenant/Resident Missing Persons and Elopement Policy and Procedure indicated it was the policy of the Program to investigate all reports of missing tenants. It a staff determined a tenant was missing from the Program staff would notify additional staff immediately to perform a thorough search of the building and grounds and if not located would notify the Executive Director and the nurse. Upon locating the tenant the nurse would examine the tenant for injuries and contact the physician. The	

	Executive Director or nurse would notify the responsible party. An incident report and investigation report would be completed. The Program's Alarmed Door Policy and Procedure for Locked Memory Unit indicated it was the policy of the Program to ensure each tenant was safe. As part of the security system in the unit all doors that led to the exterior were alarmed/coded doors. If a door alarm went off staff was to "immediately perform a physical check" of the area outside the door that alarmed to ensure that no tenant was outside of the building. Staff was then to perform a physical check of each tenant in the Program to ensure tenant safety and to ensure no tenants had exited the through the alarmed door. If additional assistance to perform a physical check of all tenants, staff would radio for additional staff and request assistance in accounting for all tenants. The Program's policy regarding walkie-talkies indicated it was to ensure staff had effective and efficient system for communication with other employees throughout the Program. All staff was to carry a walkie-talkie "on their person at all times while working." All staff was to carry a walkie-talkie with them at all times and were to respond to calls in a timely fashion. If staff heard another staff call for help and staff was unable to provide assistance they were to respond over the walkie-talkie and notify them that they were unable to assist so staff could call another staff for assistance. The Program's Staffing Policy and Procedure indicated it was the policy of the Program to maintain competent staff at all times who were able to implement the accident, fire safety and emergency procedures. Staff would have access to pagers in order to respond to the 24 hour personal emergency response device assigned to each tenant. In a dementia-specific program staff would be awake and on duty 24 hours a day in the proximate area and would check on tenants as indicated in the tenants' service plans. In summary, Tenant #1 had a history of exit seeking behavior, impaired judgement and had safety checks as indicated on the service plan. On 9-13-19 Tenant #1 left the building presumed through the front door based on alarm records. There were five staff working, including one Program staff and four agency staff. The page went off for the front door alarm and was not reset for 21 minutes. One staff was providing a shower to another tenant and could not respond; however, staff did not communicate via walkie-talkies, per policy, to determine who was responding to the door alarm. Staff did not respond immediately to the door alarms, per policy, as it was not cleared for 21 minutes. Safety checks for Tenant #1 as indicated in the service plan, hourly during the day and every 30 minutes at night, were not completed per the staffing policy. This occurred both prior to and after Tenant #1's elopement. Tenant #1 was returned to the Program by IL staff and staff failed to notify the nurse on-call until approximately two hours after Tenant #1's return to the building. Staff failed to follow the policies and procedures for door alarms, walkie-talkies and staffing and per the missing persons/elopement policy failed to notify the nurse timely for an assessment of Tenant #1 once she was located.	

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