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

Date: January 13, 2022
Program Name: Keelson Harbour Senior Living Assisted Living
Address: 2810 Aurora Ave Spirit Lake, IA 51360
Type of Action: Investigation #101175-A & 101183-M
Date(s) of Action: 12/9/21 – 12/16/21
Citation #: 5530

State Rule #	State Rule	Amount of Civil Penalty
481- 67.9(3)	**67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.** Based on record review and interview the Program failed to maintain record of documented training for all Program staff. This affected 1 of 1 sample tenant and potentially affected 22 tenants residing at the Program. Findings include: 1. Record review revealed an incident report for Tenant #1, dated 12/9/21, documented Staff went to Tenant #1's room at approximately 7:00 a.m. to complete a visual check and noticed she was not in her apartment. The report documented immediate action included: "Staff started search for resident, RA (Resident Assistant) went down the hall to her normal sitting area and could not locate her. Staff then asked her coworker for assistance. They both started searching throughout the inside of the building and then staff started searching outside for resident. Staff noted resident outside at 7:35 a.m. laying on her right side near the back of the building behind Memory Care. Staff stayed with resident until (emergency services) arrived." The report indicated the tenant was comatose at the time she was found. Continued review of progress notes indicated EMTs left the program at approximately 8:10 a.m. and the Program continued to speak with the local police regarding the events that took place. Review of the Spirit Lake Police Incident Report revealed the police had been notified of a deceased female at the Program on 12/9/21 at 8:13 a.m. When interviewed on 12/15/21 at 3:39 p.m. the Medical Examiner reported his findings that morning were consistent with the tenant exiting the building at or around 10:00 p.m. and being found at or around 7:15 a.m. the next morning. The Medical Examiner noted the tenant had been outside a while prior to being found. She was cold to the touch, and experienced hypothermia due to exposure. Rigor mortis had set in. The Medical Examiner reported Tenant #1 was dead on arrival to the hospital.	**$10000.00**

Tenant #1, 95 years-old, resided at the Program since August 2017. She had a Global Deterioration Scale (GDS) score of 5, which indicated moderately severe cognitive decline. She had diagnoses including osteoporosis and major depressive disorder. Tenant #1's service plan indicated she was an elopement risk, had a Wanderguard in place and required visual checks eight times per shift. The service plan noted Tenant #1 demonstrated deficits in judgement related to safety and had severe memory loss and a GDS of 5. Tenant #1 ambulated independently with the use of a four-wheeled walker.

According to the State Climatologist, the weather at Estherville Municipal Airport (the closest hourly reporting station to Spirit Lake) on 12/8/21 at 9:52 p.m. the temperature was 27 degrees Fahrenheit (F) with southeast winds at 20 miles per hour and a wind chill of 14 degrees F. On 12/9/21 at 6:52 a.m. the temperature was 33 degrees F with south southeast winds at 20 miles per hour and a wind chill of 22 degrees F.

2. Review of documentation revealed staff documented completion of a safety/visual check on Tenant #1 hourly between 12:00 a.m. on 12/8/21 and 2:00 p.m. on 12/9/21. RN A documented as GTT (GrapeTree Temp) hourly between 12/9/21 at 12:00 a.m. until 5:00 a.m. A different staff documented completion of a visual check at 6:00 a.m. and another staff documented a check at 7:00 a.m.

Record review revealed Nurse Delegation for visual checks directed staff should go to resident's apartment and knock on the door, enter the resident apartment, make visual contact of resident and determine whether or not the tenant is awake or asleep, document the visual check in Companion. Resident Assistant should complete checks per instructions, whether that is 8/16/32 checks per shift. It was noted a resident should be viewed throughout an entire shift to ensure their safety.

When interviewed on 12/15/21 at 10:15 a.m. Registered Nurse A was asked to describe the room check process. RN A said the room checks were documented on the iPad, and reported when staff logged in it pulled up all of the nightly duties in a Companion program. That's how she knew to do the checks. RN A did not know why the checks were completed. She reported when completing checks, she would open the door, leave the light off, go into the entryway a few steps and look for the silhouette in the tenant's bed or the recliner. RN A thought she did 15 one-hour checks, some checks every two hours, one 2:00 a.m. check and 30-minute checks on another resident on three separate floors of the Program. RN A reported she was not trained on how to conduct these checks. RN A confirmed she documented completion of checks on Tenant #1 and noted she thought she saw Tenant #1 lying in bed.

Continued record review revealed no documentation of training completed with RN A on visual checks.

3. Review of door alarms revealed the alarm at the Assisted Living Dining Exit sounded at 10:07 p.m. and was reset at 10:16 p.m.

Record review revealed the Programs Elopement Policy directed if an exit door alarm sounded, the alarm should be checked promptly. Staff should thoroughly check inside and outside areas triggered by the alarm.

Continued record review revealed Nurse Delegation for door alarm response included when staff received a notification to the walkie/iPad/pager that a door had been "breached" or "opened," staff should immediately walk to the door opened. Staff should observer inside and outside of the door to determine who last utilized the door. After knowing who came in or out of the door, the door should be reset.

When interviewed on 12/15/21 at 10:15 a.m. RN A confirmed she silenced the audible door alarm on the evening of 12/08/21 in the dining room. The nurse reported she was unsure what the alarm signified or what had caused it to alarm. After silencing the alarm, the nurse approached a Keelson Harbour employee for clarification as to why the door would alarm and was told not to worry about it. RN A reported she did not receive orientation on policies and procedures concerning emergency procedures.

Continued record review revealed no documentation of training completed with RN A on door alarms.

4. Record review on 12/15/21 revealed the signed contract between the GrapeTree medical staffing agency and Keelson Harbour/Client revealed to ensure a high quality of patient care delivery, orientation with the relevant unit setting or area as well as all applicable Client polices and procedures will be conducted by Client with the length and extent of orientation defined by Client.

When interviewed on 12/15/21 at 8:21 a. m. the Chief Human Resources Officer (CHRO) of GrapeTree medical staffing reported the Program would be responsible for the establishment of staff clinical competence during the initial orientation period and on an ongoing basis during the contract period. The CHRO reported all records of staff orientation and training with each client/facility contract would be kept at the facility. Grapetree did not maintain records specific to the Program.

On 12/16/21 at 12:35 p. m. the Manager, the Portfolio Leader and the Clinical Care Specialist confirmed record of the Registered Nurse's orientation could not be located.