IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

January 22, 2010

Incident #26384-I

Nichole Will, Director
Country House Residences
900 W. 46th Street
Davenport, IA 52806-4362

RE: Final Incident Investigation Report, Country House Residences, Davenport, IA

Dear Ms. Will:

Enclosed is the **Final incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and Iowa Administrative Code, chapters 481-67 and 69, pertaining to assisted living programs. **No Regulatory Insufficiencies were identified.**

If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 26384-I**

Nichole Will, Director
Country House Residences
900 W. 46th Street
Davenport, IA 52806-4362

Date of Incident Investigation:

December 21, 2009

Monitor(s):

Stephanie Cummins, MA

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 [321 IAC 26.2(5)(a)]. 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 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Country House Residences on December 21, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	14
Current number of tenants without cognitive disorder:	0
Total Population:	14

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

Accreditation Status – Not applicable.

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plans, Nurse Review, Food Service, Staffing, Life Safety, Structure, Record Checks and Other.

The July 28, 2009 Incident and Complaint Revisit Investigation resulted in the issuance of a Standard Certificate effective August 5, 2009 and the discontinuance of all sanctions. There were no Regulatory Insufficiencies.

The May 13 & 14, 2009 Incident and Complaint Investigation visit resulted in the continuance of the Conditional Certificate, effective, March 19, 2009 with the sanction that the program complete, document and submit documentation of training, for all staff, in regard to dementia care.

The January 23 and February 18, 2009 Complaint Investigation and Complaint Investigation Revisit resulted in a civil penalty of $2,500.00. There were substantiated Regulatory Insufficiencies in the areas of: Medications, Staffing and Other (Ensuring health, safety and well-being of tenants). A Conditional Certificate was issued, effective, March 19, 2009 with a sanction that the program complete, document and submit documentation of training, for all staff, in regard to dementia care.

The December 31, 2008 Complaint and Incident Investigation resulted in a civil penalty of $4,000.00. There were substantiated Regulatory Insufficiencies in the areas of: Medications, Life Safety, Structural Requirements and Other (not implementing the POC).

The September 2 & 3, 2008 Complaint Investigation, Complaint Investigation Revisit and Recertification Monitoring Evaluation resulted in a civil penalty of $1,500.00 with Regulatory

Insufficiencies in the areas of: Evaluation of Tenants, Service Plans, Medications, Nurse Review, Food Service, Staffing and Other.

The June 25, 2008, Incident Investigation revisit resulted in a civil penalty of $500.00 with Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Service Plans, Medications, Nurse Review Record Checks and Other.

Incident Investigation – The investigator(s) made the observations detailed in the following areas.

A. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant.

Incident Allegation: It was reported by the program that a tenant eloped and the door alarms did not sound. The tenant was redirected back to the program with staff and did not sustain any injuries.

Monitoring Observation: Tenant #1, 79 years old, was admitted on 10-1-09 with a diagnosis of Dementia. The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

According to an Incident/Accident Report dated 11-22-09 at 6:00 p.m., Tenant #1 eloped from the building and the alarms did not sound. A neighbor came to the program and asked if a tenant was missing and described the tenant. Staff went to the neighbor's house and brought the tenant back to the program. The tenant did not have any injuries, was calm and cooperative. Vitals were taken and the tenant was described as alert and disoriented. The nurse, Director and the tenant's family were notified.

Country House has four sides or pods, A, B, C and D. Currently there are no tenants in pods C and D. The current tenants reside in the front two pods A and B. The staffing pattern is one caregiver on side A and one on side B and a float, for first and second shifts. On third shift there is one caregiver on side A and one on side B.

There were no other tenants in the past 90 days that attempted to elope.

Staff #1 was interviewed and provided a written statement. She stated she was coming from the B side kitchen and went to the A side to administer medications. She observed Tenant #1 sitting in the recliner on the B side and he/she had just finished supper. This occurred at approximately 5:30 to 6:00 p.m. Approximately 15 to 20 minutes later a man came into the program and told Staff #2 a person was across the street and he thought it was one of the program's tenants. The man described the person and Staff #1 went and checked the recliner where she had last seen Tenant #1 sitting. Staff #1 stated the tenant was not there. Staff #1 went across the street and assisted the tenant in returning to the program. The tenant had no injuries and was easily redirected back to the program. Staff #1 stated the weather was mild, not warm but not cold. She also stated the alarms did not sound when the tenant left and she would have been able to hear them. Staff #1 stated another tenant returned with a visitor around the time of this incident. Staff completed 30 minute checks of the doors after the incident and a staff member sat with Tenant #1 the remainder of the shift. Staff #1 stated there was a new policy put in place in regard to the doors and the code. Staff are now required to let visitors out of the building instead of giving them the code. Staff #1 stated there were no other issues with the doors besides this incident with Tenant #1. She stated the tenant had not eloped prior to this or since. Staff #1 stated on the day of the incident she was the float staff and Staff #2 was on the A side and Staff #3 was on the B side of the building. She stated alarms from the A side can be heard on the B side and vice versa.

Staff #2 was interviewed and provided a written statement. Staff #2 stated she was assisting another tenant in the bathroom on the A side of the building. She heard someone come in the building and responded. A man asked if they were missing a tenant

because a person was in his garage looking for a vehicle. Staff #2 went and got Staff #1 and they went across the street and came back with Tenant #1. The tenant did not have any injuries and was wearing a coat and shoes, which was normal for the tenant. Staff #2 stated it was not too cold and she did not think there was any snow on the ground. Staff #2 stated she did not hear any alarms. When the alarm sounds it is loud and continuous, will continue beeping until reset and you can hear the alarms from each side of the building. She stated another tenant had a visitor earlier before supper who may have opened the door and not seen the tenant leave. Staff #2 stated the tenant had not eloped prior to or following this incident.

Staff#3 was interviewed and had a written statement. Staff #3 stated she was working on the B side of the building when the incident occurred. Tenant #1 had just finished supper and she was assisting another tenant. She did not hear the door alarm sound. Staff #2 came over first and told her Tenant #1 had eloped and she had to go and get him/her. Staff #2 told her a man had come over and asked if they were missing a tenant. Staff #1 and Staff #2 went to get the tenant and Staff #3 stayed with the other tenants. Staff #3 stated the tenant returned to the program and did not have any injuries. She said the tenant was wearing a jacket and it was cold but not snowing. Staff #1 sat with the tenant all shift upon his/her return. Staff #3 indicated once the alarm was activated it had to be manually shut off and it was loud enough to be heard on both the A and B sides of the building. She also indicated there had been family visiting another tenant in the building prior to the tenant eloping. Staff #3 stated the tenant had not eloped prior to this or since this incident.

The nurse was interviewed and had a written statement. She was notified on 11-22-09 at 6:07 p.m. that Tenant #1 had eloped and was at the neighbor's house. Staff #1 told the nurse staff brought the tenant back and there were no injuries. The nurse instructed staff to check the doors and alarms and she would call back after contacting the Director. The nurse arrived at the program at approximately 6:20 p.m., assessed the tenant for injuries and noted the tenant did not have any apparent injuries. The nurse talked to the neighbors and they indicated the tenant had been there for about 10 minutes. The Director advised the nurse to have staff check doors and alarms every 30 minutes and to document if they had any problems. The next day, the nurse reviewed the list and found no problems had occurred throughout the night with the door locks or alarms. The nurse stated staff stayed one on one with Tenant #1 throughout second shift and the tenant was sleeping on third shift. She stated all tenants received two hour visual checks following the incident. The nurse stated there had been no other elopements in the past couple of months and no issues with the door alarms. She stated the alarms on both the A and B side could be heard on either side and the alarms were loud. Staff reported they did not hear any alarms and the tenant was last observed sitting on the B side. The nurse stated anytime a door alarm goes off, a couple of staff respond to the alarm. The nurse stated there were no concerns with staffing or level of care.

The Director was interviewed and had a written statement. She stated she was notified about the elopement on 11-22-09 at 6:09 p.m. The nurse told the Director she was headed to the program. The Director stated she called the program and talked with all three staff working. At that time, the tenant was back in the building and did not have any injuries. The Director called the family to notify them of the incident. She told family she would be reporting the incident to DIA. The Director received written statements from all staff. The Director stated the alarms on both the A and B side were

loud and the alarms could be heard from each side. She stated the doors had been functioning appropriately and she did not have any knowledge of the alarms not functioning. A new policy regarding the door code was implemented and staff signed statements regarding this policy. Letters also went out to the families to notify them of the change regarding the door code and that it was for added safety and security. The Director indicated the staffing was sufficient and none of the tenants were exceeding the appropriate level of care. She stated staff respond immediately if an alarm is heard.

Staff #4, the Maintenance Director, was interviewed. He stated at least one time a day on the days he works, he checks the doors. He was notified of the elopement on 11-22-09 and staff could not re-create the issue of no alarms going off. Staff told Staff #4 they were completing checks. On 11-23-09 Staff #4 checked all doors and could not find any issues and it could not be re-created. The Director asked him to change the codes on all four keypad doors and he had to sign a sheet stating he would not give out the code. Staff #4 stated there were no issues with the doors and alarms prior to the incident and that the alarms could be heard from either the A or B side of the building.

The Director had a memo dated 11-25-09 regarding a change with door codes. As of 11-25-09 the code on the doors was changed and from that day forward any family members, visitors, vendors or anyone else inside the program would have to be let out by a staff member. The note indicated if the code was given out there would be disciplinary action. All staff signed the memo.

The program held a mandatory in-service on 11-30-09 due to the recent elopement of Tenant #1.

The elopement occurred on 11-22-09 and the program appropriately reported the incident on 11-23-09.

The program documented 30 minute checks of the doors on the A and B sides from 7:15 p.m. on 11-22-09 to 7:15 a.m. on 11-23-09 and assigned specific caregivers to complete the checks on each shift.

Staff #4 provided documentation of the door, alarm and lock tests that he completed.

- Regulatory Insufficiency: None noted.

Dated this 22nd day of January, 2010.