IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

June 1, 2010

Incident #28360-I

Ms. Jennifer Burcum, Administrator
Irving Point Assisted Living
910 7th St SE
Cedar Rapids, IA 52401-2400

RE: Incident Investigation Report, Irving Point Assisted Living, Cedar Rapids, IA

Dear Ms. Burcum:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Incident Investigation Report dated April 13, 2010. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiency If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

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

Assisted Living Program: **Incident Intake #:** 28360-I

Ms. Jennifer Burcum, Administrator
Irving Point Assisted Living
910 7th St SE
Cedar Rapids, IA 52401-2400

Date of Incident Investigation:

April 13, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH
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. IAC r. 481-67.10(5). 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 481 IAC - chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Irving Point Assisted Living on April 13, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	49
Current number of tenants with cognitive disorder:	1
Total Population:	50

Dementia Specific Program (DSP)* – Not applicable.

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

Tenant/Family Satisfaction Results – Not applicable

Program History – There were substantiated Regulatory Insufficiencies in the past certification period in the areas of: Service Plans, Life Safety and Other (lack of Dependent Adult Abuse training).

The February 11, 2010 Complaint and Incident Investigation resulted in a civil penalty of $1,000.00 and Regulatory Insufficiencies in the areas of Service Plans and Life Safety.

The August 4, 2009 Initial Certification Monitoring Evaluation resulted in a Regulatory Insufficiency in the area of Other (lack of Dependent Adult Abuse training).

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Nurse Review

During the course of the investigation, the following information was obtained:

Monitoring Observation: Tenant #1's file was reviewed. An incident log dated 4-11-10 at 10:30 p.m. indicated the tenant eloped from the building and the police department called the program to see if the tenant resided at the program. The police advised staff the tenant was with family in the ER. Staff called the Administrator because Staff #2 was concerned the alarms were not armed properly. The Administrator came in to ensure all door alarms were working properly and determined the alarms were working properly. Staff spoke to the tenant's family on 4-12-10 and indicated someone needed to be with the tenant, twenty-four hours per day, until alternative placement was found.

According to the police report dated 4-11-10 at 10:12 p.m., police were dispatched to a female wandering along 8th Avenue and police arrived at 10:17 p.m. The tenant indicated his/her name and was transported to a hospital ER. The tenant's family member arrived at the hospital.

The Patient Care Coordinator RN stated the tenant wandered in the building on occasion. She spoke to Staff #2 on 4-12-10 and he stated on the night of the elopement he had gone into the tenant's apartment for a scheduled welfare check at about 9:30 p.m. He found the tenant confused and agitated and he stayed with the tenant for what seemed like 45 minutes; however, was more likely 30 minutes. The tenant told him he/she was going to bed.

- Regulatory Insufficiency: 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 or a licensed practical nurse via nurse delegation 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. (IAC 481-r.69.27(3))

B. Other

Incident Allegation #28360-I: The program reported staff received a phone call from the police department that Tenant #1 was outside the program, confused and wandering. The tenant was taken to the ER and family was called. It was reported staff had been in the tenant's apartment for a welfare check from 9:35 p.m. through 10:00 p.m.

Monitoring Observation: Tenant #1's file was reviewed. Tenant #1 was given a 30-day written notice of transfer on 3-30-10.

An incident log dated 3-12-10, indicated that at 3:30 p.m. Tenant#1 did not enter the door code but went out of the building into the parking lot. Staff responded to the door alarm and brought the tenant back into the building. Staff reminded the tenant to use the door code. According to the incident log dated 3-29-10, the tenant was found cooking on the stove with pans and paper plates, which caused a burning smell in the hallway. Staff

aired out the apartment by opening the windows and talked to the tenant about turning off the stove for safety purposes. An incident log on the same date at 1:30 p.m. indicated the tenant was again trying to cook on the burners with paper plates. Staff explained the tenant could not cook with paper plates and the stove was turned off.

An incident log dated 4-11-10 at 10:30 p.m., indicated the tenant eloped from the building and the police department called the program to see if the tenant resided at the program. The tenant was found wandering and police advised staff the tenant was with family in the ER. Staff called the Administrator because Staff #2 was concerned the alarms were not armed properly. The Administrator came in to ensure all door alarms were working properly and determined the alarms were working properly. Staff spoke to the tenant's family on 4-12-10 and indicated someone needed to be with the tenant, twenty-four hours per day, until alternative placement was found.

According to the police report dated 4-11-10 at 10:12 p.m., police were dispatched to a female found wandering along 8th Avenue and police arrived at 10:17 p.m. The tenant indicated his/her name and was transported to a hospital ER. The tenant's family member arrived at the hospital.

The incident with Tenant #1 occurred on 4-11-10, a weekend. According to program documentation, a Certified Nursing Assistant (CNA) was available on each shift (7 a.m. - 3 p.m., 3 p.m. – 11 p.m., and 11 p.m. – 7 a.m.) on weekends. A split shift CNA was available from 7:00 a.m. until 1:00 p.m. and 4:00 p.m. until 6:00 p.m. There were also on call RN's available after hours and on weekends.

During the on-site investigation monitors, tested the door alarms and the alarms functioned appropriately. The Administrator provided a written statement regarding the alarms. She stated every time she went into the support office she visually checked the alarm panel to make sure it was armed with the padlocked symbol. The Administrator also stated the alarm went off often daily because people forgot to enter codes.

Staff #1 and #2 were interviewed and indicated there were sufficient staff to meet the needs of tenants, Tenant #1 was the only tenant who had eloped and they did not identify any tenants who exceeded the appropriate level of care. Staff #1 and #2 stated the doors and door alarms were functioning appropriately. According to the CNA schedule, Staff #2 worked 3:00 p.m. until 11:00 p.m. on 4-11-10. Staff #2 stated on the evening of 4-11-10 at 9:35 p.m. he was completing a welfare check for Tenant #1. The tenant was angry with his/her family and when Staff #2 left at 10:00 p.m. he was under the impression the tenant was going to bed as the tenant stated he/she was going to bed, the tenant was wearing jeans, a t-shirt and tennis shoes. He received a call from the police that the tenant was at a local ER. Staff #2 stated the door alarms did not sound and he left before the tenant returned to the program.

The on-call RN indicated that on 4-11-10 at 10:50 p.m. she received a call from Staff #2. Staff #2 told her he had been with the tenant until 10:15 p.m. At 10:35 p.m. Staff #2 received a phone call from the police stating the tenant was wandering and they had taken the tenant to the hospital ER. Staff #2 stated the door alarm had not gone off and the Administrator was coming in to check the door alarm. The on-call RN indicated the Administrator told her the tenant needed a family member to stay with the tenant at all times.

The Patient Care Coordinator RN stated staff had reported to her that the tenant wandered in the building on occasion. Approximately two weeks after moving into the program, one episode of wandering had been reported to her and a cognitive evaluation was completed and indicated a change in cognition. On 3-29-10 the tenant was cooking on a paper plate on the stove. The smoke smell came into the hallway which alerted the nurse. Smoke alarms did not go off and the tenant reported he/she thought it was Corningware he/she was cooking on. The tenant became extremely agitated and upset. A cognitive evaluation was deferred until the next day due to the tenant's agitation and unwillingness to cooperate. The Patient Care Coordinator RN stated when someone exits the door without entering a valid code the alarm goes off and it will ring through to the CNA's cell phone. She stated the door alarms and doors had been functioning properly. She was notified of Tenant #1's elopement at approximately at 7:30 a.m. on 4-12-10. The on-call RN was notified of the elopement at the time it happened. On 3-30-10 welfare checks were started for Tenant #1 due to a cognitive decline. Checks were completed four times daily and at the time of this investigation checks were continuing. She stated she spoke to Staff #2 on 4-12-10 and he stated on the night of the incident he had gone into the tenant's apartment for a scheduled welfare check at about 9:30 p.m. He found the tenant confused and agitated and stayed with the tenant for what seemed like 45 minutes; however, it was more likely 30 minutes. The tenant told him he/she was going to bed. The Patient Care Coordinator RN stated the tenant did not have a history of elopement prior to this incident.

Family stated police called and indicated the tenant had wandered off and was at a hospital ER. Family stated the tenant did not know the code to the door and has Macular Degeneration. Family arrived at the hospital and returned to the program at 12:15 a.m. with the tenant. Family stated the tenant was wearing pants, a t-shirt and shoes. Family was staying with the tenant twenty-four hours a day.

- Regulatory Insufficiency: None noted.

Dated this 1st day of June, 2010.