IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Incident Intake: 31379-I

December 16, 2010

Ms. Mary K. Harris, RN Manager
Oakwood Place Assisted Living
4130 Northwest Blvd.
Davenport, IA 52806

RE: Final Incident Investigation Report – Oakwood Place Assisted Living, Davenport, IA

Dear Ms. Harris:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of December 1, 2010, completed by the Department of Inspections and Appeals ("DIA") in accordance with Iowa Code chapter 231C and Iowa Administrative Code ("IAC") chapters 481—67 and 481—69. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
ASB Certification Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 31379-I**

Mary K. Harris, RN Manager
Oakwood Place Assisted Living
4130 Northwest Blvd
Davenport, IA 52806

Date of Incident Investigation:

December 1, 2010

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. 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 Oakwood Place Assisted Living on December 1, 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:	35
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	38

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	12
Total Census of ALP:	50

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

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Tenant Documents, Service Plans, Food Service, Staffing, Dementia-Specific Education, Record Checks and Other (tenant rights, lack of notification to DIA, lack of following the programs policies and procedures).

The on-site complaint and incident investigation on March 9, 10 and 11, 2010 resulted in a civil penalty of $1,500.00. There were Regulatory Insufficiencies in the following areas: Tenant Documents, Service Plans, Food Service, Staffing, Dementia-Specific Education, Record Checks and Other (tenant rights, lack of notification to DIA, lack of following the programs policies and procedures).

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

A. Other

Incident Allegation: The program reported a tenant eloped on 10-17-10 and on 10-18-10. The tenant was returned to the program without injury. The tenant's doctor and family were notified of each incident. The tenant was dressed appropriately when each incident occurred.

- Monitoring Observation: Tenant #1, an 87 year old, was admitted on 5-1-06 and diagnoses include Dysphagia, Gastro Esophageal Reflux Disease (GERD), Atrial Fibrillation, Edema, Constipation, Hypokalemia, Hypothyroid, Hypertension (HTN), Bladder Spasms, Anxiety, Congestion, and Alzheimer's Dementia. The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive impairment.

  According to Resident Notes dated 10-17-10, the tenant was returned to the building by an employee of the fabric store behind the parking garage. The tenant looked lost and reported he/she lived at the program. The tenant was in good condition and did not have any harm or injury and stated he/she was just out walking. The tenant's family was notified of the incident and felt it might have been attributed to having several relatives pass away in November and the memories associated with those events. Resident notes indicated family was aware of risks and solutions available with a secured dementia unit at the program. According to notes dated 10-17-10, the tenant continued to be restless with attempts to leave the program and stated he/she was looking for family and for his/her car. Resident Notes dated 10-18-10 indicated staff were unable to locate the tenant and a search was started inside and outside the program. The tenant was observed on the property of shopping area behind the program, according to notes. An employee observed the tenant speaking to a stranger at the center. The tenant agreed to get into the car with the employee (unfamiliar staff) and was returned to the program, according to fax to the tenant's doctor. There was no injury to the tenant and was in good spirits. The tenant was escorted to the secured dementia unit and the tenant's family was notified. The notes indicated over the past week the tenant had asked for the tenant's car more often; however, had made no attempts to leave un-escorted. The tenant had also refused activities and had been observed in the parking garage looking for the tenant's car. The parking garage was located below the program. Notes indicated the nurse spoke with family about the tenant's safety, the tenant talked to strangers while at the shopping center and got into a car with a staff member the tenant did not know. Family did not want the tenant in the secured memory care unit and indicated the tenant was too high functioning. Notes dated 10-21-10 indicated staff were monitoring the tenant's location routinely and the tenant spent much time in the tenant's apartment until lunch. There were no other attempts to leave the program at that time. Resident Notes dated 10-22-10 indicated the nurse met with family and discussed the tenant's short term memory and elopements. They discussed the risk and possible alternatives such as the secured dementia unit and a higher level of care. The nurse explained the limitations of not providing one on one staffing. Notes dated 10-25-10 indicated staff provided routine checks and there were no attempts to leave the program. On 10-26-10 the tenant was observed by the first double doors inside of the program and the tenant reported he/she was not going outside. On 10-27-10 and 10-29-10 the tenant paced the halls and was very restless. Family stayed with overnight with the tenant

on 10-30-10. On 11-2-10 notes indicated there were no attempts to leave the facility. On 11-10-10 the tenant was seen on the first floor pacing and was looking for family, according to notes.

The tenant's service plan and evaluations were updated on 10-18-10. The tenant's service plan addressed interventions related to the elopements. These included take the tenant for a walk when able, with appropriate weather and take the tenant to resale shop and return with escort. The service plan identified the tenant wore a bracelet that identified the tenant had memory problems and the tenant had keys in his/her purse that had program information on a tag. The service plan also indicated staff were to monitor the tenant's location routinely and report to nurse immediately if unable to locate the tenant. Staff were to start search immediately and notify family of episodes. The service plan identified the tenant had a history of leaving property without escorts. Staff were to provide verbal reminders to remain and explain the tenant needed to wait for family. Staff were to divert attention with activities, tell the tenant family would meet the tenant in the apartment and when looking for the tenant's car explain the family had taken the car for maintenance. The service plan also addressed the tenant had a companion that visited routinely and listed activities the tenant enjoyed. The service plan indicated the tenant was strong willed and needed to believe he/she made the decisions. Staff were to remind the tenant that he/she wanted to do something and let the tenant believe it was the tenant's idea. The service plan also indicated to notify family of all attempts to leave and signs were placed in the tenant's apartment and doorways for reminders not to leave. The service plan indicated the nurse discussed safety risks for tenant with the family. The tenant may be directed to the secure memory area during the day as he/she tolerates after notifying and approval of the nurse.

Staff #1, #2, #3, #4 and the nurse reported there had been no subsequent elopements. Staff #2 and #3 reported there were no issues completing the checks for the tenant and completing cares for the remaining tenants. Staff #1 and #4 stated cares were completed; however, it was not easy when there were not three medication aides scheduled. Staff #1 stated staff were checking the tenant routinely every 15 to 30 minutes and there had been no issues since the checks were completed. Staff #2 reported staff completed checks every 30 minutes and it was effective at the time of the incident investigation. Staff #3 reported staff checked on the tenant every 30 minutes and the tenant had not eloped since that time. Staff #2 reported the tenant was safe for "right now." Staff #3 stated the tenant was only a danger if he/she was out of the building.

The most recent documented elopement attempts prior to October 17 and 18 elopements occurred in March 2010. The tenant had gotten to the door; however, had not gotten out of the door, according to Resident Notes.

The nurse reported the tenant was not harmed with two elopements on 10-17-10 and 10-18-10. The tenant had a history of wandering and had an episode in March; however the tenant did not leave at that time. The tenant liked to go to the parking lot and look for his/her car. The tenant had not left the property previously, according to the nurse. The nurse reported there had been no harm, injuries or falls with any of the incidents. The nurse stated checks were started every half hour, staff tried to get the involved with activities, staff took the tenant on walks when possible, the tenant had

an outside companion to take the tenant out and the tenant played cards with other tenants. The nurse reported the interventions were managing the elopement behaviors at the current time. The nurse reported the tenant was a danger if the tenant left un-escorted and she had concerns about it re-occurring, which is why checks were started. The nurse stated the tenant was safe right now with interventions in place and she would not give transfer notice today.

A family member was interviewed. This family member was the tenant's legal representative. The family member reported he/she was well aware of the risk and the family wanted their loved one to be where he/she was the happiest and wanted to keep the tenant fulfilled. The tenant was interviewed and reported he/she liked the apartment and the view out of the window. The tenant stated he/she felt safe.

According to Incident Reports dated 10-17-10 and 10-18-10, the tenant was returned with each incident without injury or harm and was dressed appropriately. The tenant's family and doctor were notified of each incident. An incident report was completed for each incident and the program notified the department appropriately regarding the incidents. The interventions were in place after the elopements and there had been no subsequent elopements.

The program received a quote from the HomeFree Inc., on 11-19-10 to add door monitoring equipment. The Executive Director (ED) called the HomeFree account representative to inquire about a time frame for installing door monitoring hardware for the program. The representative was not available; however, the ED estimated based on previous experience the equipment arrival on-site and installation would take between two to four weeks.

- Regulatory Insufficiency: None noted.

Dated this 15th day of December, 2010.