IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 34765-I

August 18, 2011

Ms. Jennifer West, Director
Amber Ridge Assisted Living
107 E. Second Street
DeWitt, IA 52722

RE: I. Final Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. West:

I. Final Incident Investigation Report – Amber Ridge Assisted Living, DeWitt, IA

Enclosed is the **Final Incident Investigation Report** 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. The Report notes Regulatory Insufficiencies in the area(s) of: Criteria for Exclusion of Tenants and Other (non-notification to Department). **Amber Ridge Assisted Living** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on July 29, 2011, has been reviewed and will constitute the final POC related to the on-site visit of June 30, 2011.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 34765-I**

Jennifer West, Director
Amber Ridge Assisted Living
107 E. Second Street
DeWitt, IA 52722

Date of Incident Investigation:

June 30, 2011

Monitor(s):

Lori Miner, RN BSN
Margaret Kaltefleiter, RN MS

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 Amber Ridge Assisted Living on June 30, 2011. 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:	18
Current number of tenants with cognitive disorder:	2
Total Population:	20

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 – A meeting with the tenants was not held.

Program History – The program received a regulatory insufficiency in the area of medications during this certification period.

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

A. Criteria for exclusion of Tenant.

Incident Allegation: On 6-28-11 the program reported Tenant #1 left the building without staff knowledge.

- Monitoring Observation: Tenant #1 (the Tenant), an 85 year-old, was admitted to the program on 5-13-11 with a diagnosis of dementia. The Tenant was staged at five on the Global Deterioration Scale (GDS) on 6-15-11 which indicated moderate severe cognitive decline. A history and physical form dated 5-6-11 and signed by the physician indicated the Tenant was seen because the family was concerned when the Tenant went for a walk and could not get back home. The Tenant was on Namenda and Aricept, medications for dementia, but the Tenant continued to show decline. A prescription pad note dated 5-6-11 and signed by a physician indicated the Tenant was encouraged to go into a program that deals with persons with dementia. An incident report indicated on 6-27-11 at 6:30 p.m. a staff person went to do a visual check of the Tenant. The Tenant was not in the apartment. Staff went to check outside the building and noticed the Tenant across the street with an off-duty staff person. The Tenant was escorted back to the building. The incident report indicated the Tenant did not know he/she needed to tell anyone or wait for an escort to go walking. The incident was appropriately reported to the department.

  An interview was conducted with Staff #1, the off-duty staff person. Staff #1 indicated she was riding a bicycle at the corner across from the facility and noticed Tenant #1 crossing the street diagonally to the sidewalk. After a brief walk with Staff #1, the Tenant was escorted back to the building.

Incident reports were reviewed for Tenant #1. On 5-16-11, a local automotive shop located approximately nine blocks away phoned to say Tenant #1 was there. A family member returned the Tenant to the program. The incident report indicated the Registered Nurse (RN) discussed with the daughter the need for scheduled daily walks. On 6-8-11 the Tenant was observed going out the door. Staff caught up with the Tenant three-fourths of the way down the block.

On 6-14-11 the Tenant was seen "walking down the public street-almost ¾ of a block" and staff directed the Tenant back to the building. The incident report indicated the program was instituting visual checks every 15 minutes, posting reminders inside the Tenant's apartment, using re-direction, and continuing with the family coming every evening to walk with the Tenant. A managed risk agreement was signed by the Tenant and the Tenant's Power of Attorney (POA) on 6-15-11.

The visual checklists were reviewed. A notation was made by the 6:30 a.m. record for 6-18-11 that indicated the door alarm sounded and the Tenant was standing outside and was not easily redirected. At 1:30 p.m. a notation was made that between checks the Tenant had walked half-way down the block. At 4:15 p.m. a notation was made that the Tenant was ready to go out the door, but the Tenant was "caught." On 6-19-11 a notation indicated the Tenant was checked at 7:00 p.m. and at 7:10 p.m. the Tenant was "all the way down the block." No incident reports were provided to document the notations on the visual checklists.

In an interview with Staff #1, she indicated approximately two weeks ago she was walking up the east hall and saw Tenant #1 walking outside by the front window. Staff #1 went out and asked the Tenant to come in. Staff #1 indicated an incident report was not completed. An interview with Staff #2 revealed that on 6-29-11, approximately 6:30 p.m. the door alarm sounded and Staff #2 went to the door to find Tenant #1 in the middle of the parking lot. Staff #2 indicated Tenant #1 has left the building at least five times.

The building was noted to be rectangular in shape with offices and the kitchen down the center. Depending on location, the direct line of sight to the exit doors was partially to completely obstructed by the center office structures. Exit doors were located at both ends of the building. It was noted the doors alarmed with entry and exit. Staff #1 indicated the door alarms were deactivated for activities, especially musical activities. Staff #2 indicated alarms were deactivated when tenants move in or with musical activities. Staff #2 indicated she does not always hear alarms when she is working with another tenant. Nurse's notes dated 6-28-11 indicated the elopement of 6-27-11 was discussed with the POA and it was recommended the Tenant have an individual wander alert purchased.

The Tenant was admitted to the program on 5-13-11 with Dementia and a history of walking and not being able to get back home. The Tenant left the building on 6-14-11 which prompted the institution of reminders, visual checks, re-direction, scheduled walks, and a managed risk agreement. The Tenant has left the building without staff knowledge at least four times since interventions were implemented. The most recent attempt to leave was 6-29-11, the day before the onsite visit.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who is dangerous to self or other tenants or staff, including but not limited to a tenant who despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression.
(IAC r. 481-69.23(1)(c)(1))

B. Other

- Monitoring Observation: During the course of the investigation, the following was noted: Tenant #1 (the Tenant), an 85 year-old, was admitted to the program on 5-13-11 with a diagnosis of dementia. A history and physical form dated 5-6-11 and signed by the physician indicated the Tenant was seen because the family was concerned when the Tenant went for a walk and could not get back home. The Tenant was on Namenda and Aricept, medications for dementia, but the Tenant continued to show decline. The RN noted the history and physical form on 5-10-11. A prescription-pad note dated 5-6-11 and signed by a physician indicated the Tenant was encouraged to go into a program that deals with persons with dementia.

  Incident reports were reviewed for Tenant #1. On 5-16-11, a local automotive shop located approximately nine blocks away phoned to say Tenant #1 was there. Google Maps, using the most direct route, showed the distance from the program to the automotive shop was just under one mile. A family member returned the Tenant to the program. An interview was conducted with a worker at the automotive shop. The worker indicated a person had walked into the shop asking to use the phone, then asked the worker to make the call. The person gave the name of someone to call, but not the number. The worker looked up the number in the phone book and called. The worker reported the person was dressed appropriately but seemed "disoriented." The automotive shop was noted to be on a four-lane road.

  The service plan dated 5-10-11 indicated Tenant #1 was noted to have short-term memory loss and was classified as having mild impairment. Mild impairment was described as having some confusion, difficulty in remembering details and forgetfulness, which indicted the Tenant may need initial guidance.

  The Director indicated the program did not notify the department because Tenant #1 was staged at two on the GDS scale at the time.

  The program failed to notify the department when Tenant #1 eloped on 5-16-11.

- Regulatory Insufficiency: Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program.
(IAC r. 481-67.4(4))

Dated this 17th day of August, 2011.