IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**Incident Intake #: 35854-I**

October 3, 2011

Ms. Patty Youll, Administrator
Stonebridge of Milford Assisted Living
1401 H Avenue
Milford, IA 51351

**RE: Final Incident Investigation Report – Stonebridge of Milford Assisted Living, Milford, IA**

Dear Ms. Youll:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of September 21, 2011, 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 515/281-4116.

Sincerely,

*Jim Berkley*

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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# IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
## Assisted Living Program
## Final Incident Investigation Report

**Assisted Living Program:**

**Incident Intake #: 35854-I**

Patty Youll, Administrator
Stonebridge of Milford Assisted Living
1401 H. Avenue
Milford, IA 51351

**Date of Incident Investigation:**

September 21, 2011

**Monitor(s):**

Hal L. Chase, RN BSN MPH

**Definitions:** ***The following definitions are relevant:***

**Assisted Living Program** – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

**Dementia-Specific Assisted Living Program** - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

**Regulatory Insufficiency** - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

**Overview**: ***In preparing this report, the following information was considered:***

**Current Program Census**

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

| | General Population Program |
|---|---|
| Number of tenants without cognitive disorder: | 22 |
| Number of tenants with cognitive disorder: | 0 |
| Total Population of Program at time of on-site | 22 |
| **TOTAL census of Assisted Living Program** | 22 |

**Program History** – There were no regulatory insufficiencies found during this certification period.

**A. Service Plans**

Incident Allegation: The Program reported Tenant #1 (the Tenant) went out for a morning walk the morning of 9-4-11. Staff noticed after 45 minutes, the Tenant had not returned. Shortly thereafter, the Tenant was brought back by local police. The Tenant was moved from the Program to the adjacent nursing facility.

- Monitoring Observation: The Tenant, sn 87 year old, was admitted on 8-11-10 and had diagnoses of: Coronary Artery Disease, Dyslipidemia and Osteoarthritis. A cognitive evaluation was completed on 9-1-11 and staged the Tenant at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. A GDS completed on 7-8-11, staged the Tenant at three, which indicated mild cognitive decline. The service plan of 7-8-11 indicated the Tenant needed assistance with bathing and medication administration, but was independent with all other activities of daily living (ADLs).

  Nurse's notes of 8-23-11 indicated the Tenant was admitted to the hospital for surgery and return on 8-24-11. The Nurse completed a nurse review at that time reported no change in the Tenant's health status. Nurse's notes of 8-26-11 indicated staff reported the Tenant had increased confusion and complained of pain upon urination. The Nurse completed a nurse review, notified the Tenant's physician of the Tenant's status. The Tenant was seen by a physician and returned to the Program with orders for Milk of Magnesia and Biscodyl. On 8-29-11 staff reported the Tenant was incontinent of urine over the weekend and needed "step by step instructions" in completing ADLs.

  Nurse's notes of 9-1-11 indicated the Administrator met with the Tenant's family member and discussed the Tenant's need for increased care. The Tenant's family member understood the Tenant's need for increased care and understood the need to prepare for future placement in a nursing facility. Nurse's notes of 1-14-11 through 9-1-11 noted no incidents of wandering or increased confusion. An incident report of 9-4-11, indicated the Tenant went out for his/her daily walk at approximately 9:15 a.m. At 10:00 a.m., staff realized the Tenant had not returned and notified the Nurse.

Staff went outside to look for the Tenant and local police arrived with the Tenant. The Nurse reported the Tenant had told the police he/she couldn't find his/her way back to the program. The Tenant had his/her identification necklace on.

The Administrator and Staff #1 and Staff #2 reported the Tenant would walk daily outside the program. The Tenant would leave around 9:00 a.m. – 9:15 a.m. and would return sometime before 10:00 a.m. Staff #1 and Staff #2 reported they had seen the Tenant earlier the morning of 9-4-11, during cares and at breakfast and noted no increased confusion. The Tenant was discharged from the Program the day of the incident and was admitted to the local nursing facility.

- Regulatory Insufficiency: None noted.

Dated this 21st day of September, 2011.