IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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LT. GOVERNOR

Complaint/Incident Intake #: 37017-C
36946-I
37034-I

December 23, 2011

Ms. K'Lee Latham, Administrator
Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

RE: Final Complaint/Incident Investigation Report – Shores at Pleasant Hill, Pleasant Hill, IA

Dear Ms. Latham:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 12, 13 and 14, 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 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

K'Lee Latham, Administrator
The Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

Complaint/Incident Intake #: 37017-C
36946-I
37034-I

Date of Complaint/Incident Investigation:

December 12, 13 & 14, 2011

Monitor(s):

Stephanie Cummins, MS
Margaret Kaltefleiter, RN MS
Ann Martin, RN

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	47
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	52

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	4
Number of tenants with cognitive disorder:	14
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	70

Program History –
The program received regulatory insufficiencies in the areas of: Evaluation, Service Plan and Medications during the recertification and complaint (30944) visit of 9-30 and 10-4-2010.

During the complaint visit (32829, 32397, 32916) of 2-21, 22-2011, the program received regulatory insufficiencies in the areas of: Tenant Rights and Staffing

During the complaint visit (33891) of 6-1-11, the program received a regulatory insufficiency in the area of Occupancy Agreement.

During the complaint visit (35062, 35115, 35787) of August 29 and 30 and September 12 and 13, 2011, the program received regulatory insufficiencies in the areas of: Policy and Procedure, Medication, Staffing, Evaluation, Criteria for Admission and Retention, Tenant Documents and Nurse Review.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Medications

Complaint/Incident Allegation #36946-I: The Program reported a staff nurse falsified a narcotics record.

Monitoring Observation: Tenant #1 (the Tenant), a 77 year old, was admitted on 11-1-10 and diagnoses include Alzheimer's Disease, Dementia, Diabetic, Hallucinations, Confusion, Heart Valve Defect, Mental Illness and Paranoid Schizophrenia. The Tenant was staged at a four on the Global Deterioration Scale (GDS), which indicated

moderate cognitive decline. The Tenant resided in a secured unit. The Tenant had an order for Ativan 0.25 mg three times daily as needed noted on 8-19-11. On 11-29-11 at 2:30 p.m. a fax was sent to the Tenant's physician and indicated the Tenant had increased restlessness and anxiety. An order for Ativan 0.5 mg one tablet by mouth three times every day was requested. The Tenant's physician ordered Ativan 0.5 mg one tablet by mouth three times every day.

Tenant #2 (the Tenant), a 93 year old, was admitted on 5-8-08 and diagnoses include Hypotension, Dementia, Myalgia and Syncope. The Tenant was staged at a six on the GDS, which indicated severe cognitive decline. The Tenant resided in a secured unit. According to the Medication Administration Record (MAR), Ativan 0.5 mg one tablet by mouth three times daily was ordered.

According to a Medications Error Report, on 11-29-11 at 2:20 p.m. Staff #5 gave Tenant #1 0.5 mg of Ativan instead of Ativan 0.25 mg as needed ordered. Staff #5 took another tenant's pill that was a different strength than what was ordered.

According to a Program record and staff statements, on 11-29-11 Staff #5 realized after count started that she had administered one of Tenant #2's medication to Tenant #1 and she told Staff #4 of her mistake. Staff #4 covered up the medication error by changing the count. Staff #3 came on duty at 3:30 p.m. on 11-29-11 and noticed medication count was falsified and was not comfortable with what Staff #4 had done. Staff #4 reported the medication error and that she had changed the medication count to the Administrator. After an investigation of the medication error and falsification of the medication count was completed it was determined Staff #4 would be terminated. A meeting was held with Staff #5 regarding the medication error and she provided a statement. She was given a written warning and placed on a two week suspension. The Director of Health Services was unable to find the medication count records from the medication error. The Program investigated the missing documents related to the medication error. Staff #6 admitted to taking the two narcotic sheets and indicated she flushed them down a toilet. Staff #6 was terminated on 12-1-11.

On 11-29-11 at 4:50 p.m. Tenant #1's physician was notified the Tenant received 0.5 mg of Ativan instead of 0.25 mg and no adverse reactions were observed. Staff #4 completed the Medications Error Report dated 11-29-11 at 5:00 p.m. A nurse review was completed on 11-30-11 for observed increased restlessness and increased in times the Tenant received the as needed medication and that it was not always effective. The nurse review also indicated the Tenant received 0.5 mg dose of Ativan instead of 0.25 mg with no adverse reactions. An order was sought on 11-29-11 at 2:30 p.m. for Ativan 0.5 mg three times daily. Another nurse review was completed on 12-1-11 for a change in medication and the medication error.

At the time of the investigation, Tenant #1's current order for Ativan was 0.5 mg three times every day, which was what the Tenant #1 received in the medication error on 11-29-11. Tenant #2's medication was replaced at the Program's expense.

According to a Record of Corrective Action and a Program document, Staff #5 received a written warning for administering a wrong medication to a tenant on 11-29-11. Staff #5 was placed on a two week suspension per policy as she had a

previous medication error. Staff #5 would be re-delegated on medications before passing any medications. Staff #5 quit on 12-2-11 and did not return to work at the Program.

According to a Record Corrective Action, Staff #4 was terminated effective 11-30-11 for falsification of a document. On 11-29-11 Staff #4 was made aware of a medication error and falsified the record to cover up the medication error, according to the form. The Program reported the incident to the Iowa Board of Nursing (IBON).

Staff #1, #2 and #3 had nurse delegation on medication administration and narcotics. A medication pass was observed and appropriate medication protocol was followed.

A medication error report was completed, Tenant #1's physician was notified, Tenant #1 did not have any adverse reactions, and nurse reviews were completed after the medication error. Corrective action was taken regarding the staff involved. Staff had appropriate nurse delegations regarding medications and an appropriate medication pass was observed at the time of the investigation. Tenant #1's Ativan was increased to 0.5 mg three times every day on 11-29-11, which was the dose the Tenant received in the medication error. At the time of the investigation Tenant #1 remained on that dose of Ativan. Tenant #2's medication was replaced at no cost to the Tenant. The Program reported the incident to the Department and to the IBON.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #37017-C: It was alleged medications were found in inappropriate places within the building.

- Monitoring Observation: A medication pass was observed and appropriate medication protocol was followed. Staff #1, #2 and #3 had nurse delegation on medications.

  The monitors were throughout the building during the three day investigation and were in several tenant apartments and did not observe any medications in inappropriate places within the building.

  Four tenants and one family member were interviewed. Those tenants that received assistance with medications received the medications appropriately and did not observe them in inappropriate places within the building.

  Nine tenant files were reviewed and MARs for those tenants that received medication administration had medications that were consistently documented as administered.

  Staff #1 and Staff #2 stated medications were not observed in inappropriate places in the building and they observed tenants swallowing medications. The Director of Health Services stated one staff member found a pill in the hallway with the coating off of it and there was no way to know where it had come from. She expected staff to report if they found medication on the ground. She said as part of the nurse delegation staff was instructed to observe tenants swallow medications. The

Administrator said one pill was found on the floor by the front door and the Director of Health Services was contacted.

- Regulatory Insufficiency: None noted.

B. Service Plans

Complaint/Incident Allegation #37017-C: It was alleged services were not provided as promised.

- Monitoring Observation: Nine tenant files were reviewed.

Tenant #4 (the Tenant), an 82 year old, was admitted on 9-17-11 and diagnoses include Congestive Heart Failure, Dementia, Arthritis, Hypertension (HTN) and Diabetes. The Tenant was staged at a three on the GDS, which indicated mild cognitive decline. The Tenant was discharged on 11-12-11. The Tenant resided in a secured unit. The Tenant had evaluations and a service plan completed prior to taking occupancy, when moved to a secured unit and within 30 days of occupancy. According to an Incident/Accident Report, on 11-11-11 at 12:50 p.m. the Tenant was with a group and had left the group when staff turned around. Staff immediately started to follow procedure. Staff #1 stated when taking the Tenant back upstairs, another tenant was trying to leave the group and she turned around to tell the other tenant not to go when she turned back the Tenant was gone. Nurse review, evaluations and a service plan were completed after the Tenant exited the building. The nurse review indicated there had been no harm to the Tenant, the Tenant had not made any attempts to leave in the past and routinely made good choices. The service plan was updated as needed and reflected the services to be provided.

Tenant #5 (the Tenant), an 87 year old, was admitted on 9-17-11 and diagnoses include HTN, Depressive Disorder, Senile Dementia, Left Humerus Fracture and Chronic Pain. The Tenant was staged at a six on the GDS, which indicated severe cognitive decline. The Tenant was discharged on 11-12-11. The Tenant resided in a secured unit. The Tenant had evaluations and a service plan completed prior to taking occupancy, when moved to a secured unit and within 30 days of occupancy. On 9-20-11, a nurse review was completed and the service plan updated to reflect the Tenant would be checked every two hours for bathroom needs during the daytime and every four hours during sleeping hours and to watch for any problems with the skin. The nurse review also indicated the Tenant was moved to a secured unit due to an increased need for services. According to the Health Profile Notes dated 9-22-11, the physician was contacted and an antibiotic was requested due to signs and symptoms of a Urinary Tract Infection (UTI). On 9-23-11, the physician ordered an antibiotic for five days and to encourage fluid intake. A nurse review was completed on 9-23-11 due to the Tenant's increased urgency, frequency and concentration of urine and the physician's order for an antibiotic for five days. The service plan was updated to reflect the antibiotic treatment. Increased confusion was also noted due to the possibility of a UTI. The MAR reflected that an antibiotic was administered as ordered from 9-23-11 through 9-27-11. On 10-5-11, the physician was notified the Tenant had a red area on the coccyx measuring 2.0 cm. wide by 7.0 cm. long. The

area was red and soft but not an open wound. The Tenant also had an area on the right buttock measuring 2.0 cm wide by 6.0 cm. long. Home care services were requested. On 10-6-11, a physician order was received for home care services.

The Administrator stated to her knowledge, the Tenant did not have any wounds at the time of admission. The Program did not provide the wound care as the Tenant's legal representative requested a home health agency and did not want the Program to provide the wound care. She stated the Tenant would refuse to get out of the wheelchair and reposition to relieve the pressure on his/her bottom.

A 30 day nurse review was completed on 10-6-11 that indicated the Tenant's skin was pink and warm with dry areas to coccyx, spine and right buttock. The nurse review indicated an order was received for Physical Therapy (PT), Occupational Therapy (OT) and home health care for evaluation and treatment of the skin and for a positioning cushion. The service plan was updated on 10-6-11 and reflected interventions for staff to encourage the Tenant to lie down in the afternoons, to make sure the air mattress was plugged in and to position Tenant on the unaffected side. The service plan also reflected the coordination of services with the home care agency for PT/OT and home health services for wound care. A nurse review completed on 10-14-11 reflected the Tenant's skin had multiple areas of concern: sacral area, buttocks, and top of feet and home health provided wound care. A home health skilled nurse admission evaluation visit note dated 10-11-11 indicated a posterior right gluteus maximus pressure ulcer 3.0 cm long, 2.5 cm wide and 0.0 cm deep; a posterior sacrum pressure ulcer .6 cm long, 1.5 cm wide and 0.0 cm deep; a posterior left gluteus medius pressure ulcer 4.0 cm long, 7.0 cm wide and 0.0 cm deep; an anterior left dorsal foot pressure ulcer 2.0 cm long, 1.0 cm wide and 0.0 cm deep; an anterior right dorsal foot pressure ulcer .80 cm long, .20 cm wide and 0.0 cm deep; and a posterior thoracic area pressure ulcer 1.20 cm long and 1.0 cm wide. The visit note indicated the wounds were cleaned with warm water, patted dry and dressings were applied. The visit note stated the pressure on the foot came from shoes that the Tenant wore. Skid resistant socks were put on the Tenant. A home health skilled nurse visit note dated 10-14-11 indicated old dressings were removed, the wounds were cleaned with warm water, patted dry and dressings applied. The skilled nurse visit note dated 10-21-11 indicated the nurse instructed the Tenant in his/her role in helping heal the pressure ulcers by not lying on the back when in bed. A home health nurse showed the Tenant a picture of the stage 1 pressure ulcers on the spine. A home health nurse instructed the Tenant to stay off his/her back so that it could heal. The Tenant smiled and stated he/she laid on his/her back. According to a summary entry in the Health Profile Notes dated 11-16-11, the Tenant was admitted to the hospital on 11-3-11 for evaluation and treatment of areas on the skin. The Tenant was discharged from home health care services on 11-3-11. The Tenant was discharged from the Program on 11-12-11. The service plans were updated as needed and reflected the services to be provided.

Tenant #7 (the Tenant), an 87 year old, was admitted on 8-2-10 and diagnoses include Dementia, HTN, Irregular Heartbeat, Parkinson's Disease, Prosthesis, Osteoporosis and Hearing Loss. The Tenant was discharged on 11-21-11. A nurse review was completed on 10-26-11 related to change in bowel medications and the nurse review indicated the condition was addressed in the current assessment and service plan. A nurse review was completed on 11-2-11 for nausea and vomiting and the nurse

review indicated the condition was addressed in the current assessment and service plan. On 11-4-11 a nurse review was completed related to a fall and the nurse review indicated the condition was addressed in the current assessment and service plan. A nurse review was completed on 11-7-11 related to the Tenant falling backwards in the wheelchair and hitting his/her head on the entry door when family assisted the Tenant. The nurse review indicated the condition was addressed in the current assessment and service plan. A nurse review was completed 11-8-11 related to when the Tenant went out to the emergency room (ER) for evaluation of a fall and the Tenant returned with an order for an antibiotic for sinus infection. The nurse review indicated the condition was addressed in the current assessment and service plan. The service plan was updated as needed and reflected services to be provided.

Tenant #9 (the Tenant) an 84 year old was admitted on 9-8-10 and diagnoses include Dementia, Prostrate Cancer, HTN, Deep Vein Thrombosis, Agitation, Threats of Violence and Hallucinations. The Tenant was staged at a six on the GDS, which indicates severe cognitive decline. The Tenant resided in a secured unit. An Incident/Accident Report dated 10-12-11, indicated another Tenant told staff the Tenant was on the floor. When staff entered the Tenant's room, the Tenant was seen kneeling on one knee and stated he/she did not know what happened. The Tenant had a history of bending over and picking items up off the floor. The Tenant denied any injury. The family and physician were notified. An Incident/Accident Report dated 10-13-11, indicated the Tenant's family member requested help assisting the Tenant off the floor. The Tenant had slipped on water on the floor due to the family member washing out the Tenant's pants in the bathroom. According to the Health Profile Notes dated 10-13-11, the Tenant stated his/her back was fine and he/she did not have any pain. A nurse review was completed on 10-13-11 due to both falls. The service plan was updated on 10-14-11. According to the Health Profile Notes dated 10-24-11, the Tenant's left ear was bleeding. The Tenant was taken to the ER for an evaluation. The Tenant returned with orders for four ear drops to be administered three times a day and an antibiotic to be administered twice a day for ten days. A nurse review was completed and the service plan was updated regarding the bleeding ear and medication orders. The service plan was updated as needed and reflected the services to be provided.

Four tenants and one family member were interviewed. The tenants received the services promised and staff responded when they requested assistance. They did not voice any concerns regarding cares. Staff #1 and Staff #2 stated there was enough staff to meet the identified needs of the tenants and none of tenants exceeded the appropriate level of care. Staff #1 and Staff #2 stated tenants did not voice concerns regarding lack of staff. Staff #1 and Staff #2 stated tenants received the cares they required. The Administrator and the Director of Health Services stated there was enough staff to meet the identified needs of the tenants and none of the tenants exceeded the appropriate level of care. The Administrator and Director of Health Services stated tenants received the cares they required.

Per review of tenant files, staff interviews, tenant and family interviews, interviews with the Administrator and Director of Health Services and review of occupancy agreements, the tenants received the services they requested and required. The occupancy agreement indicated the Program was under no obligation to provide any

services to the tenants other than the services in agreement and in the service plan. The service plans were updated as needed and reflected services to be provided.

- Regulatory Insufficiency: None noted.

C. Other

Complaint/Incident Allegation #37034-I: The Program reported a tenant eloped without staff knowledge. The tenant had no previous history of exit seeking or elopement. The tenant was returned without injury.

Complaint/Incident Allegation #37017-C: It was alleged a tenant eloped.

- Monitoring Observation: The Program identified two tenants, one tenant who had eloped from the building and another tenant who had exited the building. Tenant #3 was identified as the tenant who had eloped.

  Tenant #3 (the Tenant), a 77 year old, was admitted on 4-1-11 and diagnoses include Bipolar, Hallucination and Confusion. The Tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. The Tenant resided in a secured unit at the time of investigation; however, at the time of elopement the Tenant resided in the assisted living.

  According to an Incident Report and Investigation report, on 12-6-11 at 1:15 p.m. the Tenant went for a walk down the street and wanted to go home. There were no injuries to the Tenant and no complaints of pain. The Tenant's physician and family were notified. An assessment of the Tenant was completed when the Tenant returned. The Tenant did not have a history of any similar incidents. The Tenant was moved to secured unit.

  According to a Program record, on 12-6-11 at approximately 1:15 p.m., the Tenant walked out of the Program door without staff knowledge. At approximately 1:20 p.m. staff entered the dining room to escort the Tenant back to his/her apartment. At that time it was observed the Tenant was not sitting at the table with his/her friends as he/she was last seen. An immediate search was started. The Tenant walked approximately two blocks within the neighborhood of the Program. A neighbor saw the Tenant, picked him/her up and drove the Tenant to the police station. At approximately 1:40 p.m. a police officer called the Program and the Administrator picked up the Tenant and drove him/her back to the Program. The Tenant returned to the building at approximately 1:50 p.m. The Director of Health Services assessed the Tenant and the Tenant was unharmed, did not appear to be upset and vitals were stable. On 12-1-11 the Tenant changed apartments from independent living on one floor to assisted living on another floor. Escorts to and from meals were provided to help the Tenant adjust. The Tenant had not been exit seeking, had never attempted to

leave the Program without assistance or staff knowledge prior to the elopement on 12-6-11. The Tenant was gone from the building approximately 35 minutes. The Tenant was dressed in an undershirt, another long sleeved shirt, a velvet jacket, long pants and appropriate foot wear. The Tenant's family and doctors were notified. The family member came to the Program and met with the Director of Health Services. The Tenant was moved to a secured area during the evening on 12-6-11 and the family decided to move the Tenant to a new apartment in a secured unit on 12-7-11.

A nurse review, evaluations and a service plan were completed for increased services and the move to the assisted living. A nurse review was completed on 12-6-11 related to the elopement and there was no injury to the Tenant noted during the assessment. Nurse reviews, evaluations and a service plan were completed related to the elopement and move to a secured unit. The service plan dated 12-7-11 indicated the Tenant could wander in the dementia unit safely, staff to observe for any exit seeking behaviors and redirect away from the doors when necessary. Staff to engage the Tenant in an activity, snack or engage in one on one conversations. Nurse reviews, evaluations and service plans were completed as needed with the move to the assisted living and after the elopement with the move to a secured unit.

The Director of Health Services stated there were no tenants that exceeded the appropriate level of care and there was enough staff to meet the needs of the tenants. She said the Tenant had never wandered or attempted to elope before. At 1:15 p.m. one of the staff said the Tenant was not in the dining room, a room to room search and floor to floor search was started. The police called and they had the Tenant and the Administrator went to pick up the Tenant. She did an assessment of the Tenant upon the Tenant's return. There were no injuries to the Tenant. There had not been any subsequent elopement attempts.

The Program provided a copy of the Missing Tenant policy and procedure and the Program followed their policy.

An incident report was completed related to the incident. The Department was notified of the elopement, as a Tenant with impaired decision making ability left the building without staff knowledge.

According to the State Climatologist the weather on 12-6-11 at 1:10 p.m. was 21 degrees, 68% humidity, winds from the northwest at 7 miles per hour, wind chill at 13 degrees and it was mostly sunny.

The Program identified two tenants, one tenant who had eloped from the building and another tenant who had exited the building. Tenant #4 was identified as the tenant who had exited the building. Tenant #4's file was reviewed.

According to an Incident/Accident Report, on 11-11-11 at 12:50 p.m. the Tenant was with a group and had left the group when staff turned around. Staff immediately started to follow procedure. Staff #1 stated when taking the Tenant back upstairs, another tenant was trying to leave the group and she turned around to tell the other tenant not to go when she turned back the Tenant was gone.

According to a Program record, on 11-11-11 at 12:44 p.m. the Tenant left the dining to go with a group of tenants to enter the elevator. The Tenant instead turned to exit the service door. After exiting the service door, the Tenant began talking to family members about needing a ride home. The Tenant told the family members that his/her house was two miles away and gave them the address. The family drove the Tenant to his/her destination; however, the family members saw the Tenant's pendant and drove the Tenant back to the Program. At 1:00 p.m. staff met the car when they drove back to the Program. Staff was inside the building and outside the building looking for the Tenant. The police were called and an officer came to the Program. The Tenant was happy when he/she returned and was not in any distress. The Tenant was dressed appropriately. The Tenant's family and physician were notified. The Program record indicated the Tenant had a GDS of three and routinely made good decisions and it was not a reportable incident.

Nurse review, evaluations and a service plan were completed after the Tenant exited the building. The nurse review indicated there had been no harm to the Tenant, the Tenant had not made any attempts to leave in the past and routinely made good choices.

The Director of Health Services stated there were no tenants that exceeded the appropriate level of care and there was enough staff to meet the needs of the tenants. She said one time when the Tenant was first admitted he/she walked around the building and then came back into the building. The Tenant could come and go as he/she wanted as the Tenant was not in a secured unit at that time. The Tenant was moved to a secured unit on 9-20-11. In regards to the 11-11-11 incident, she said the Tenant got outside, he/she got into a visitors car and they a drove short distance. The Tenant was returned to the Program and did not have any injuries.

The Program provided a copy of the Missing Tenant policy and procedure and the Program followed their policy.

According to the State Climatologist the weather on 11-11-11 at 12:54 p.m. was 47 degrees, 54% humidity, winds from the southwest at 6 miles per hour and partly cloudy skies.

An incident report was completed related to the incident on 11-11-11. The Department was not notified of the elopement. The Tenant had mild cognitive impairment at a GDS of three and the Tenant made good decisions. The other incident that occurred when the Tenant was able to come and go as the Tenant pleased was not required to have an incident report and not required to be reported to the Department. There was no other documentation in the Tenant's file or incident reports regarding any other elopement attempts.

Review of nine tenant files, incident reports, staff interviews, an interview with the Director of Health Services and the Administrator indicated Tenant #3 was the only tenant to have an elopement required to be reported to the Department. Tenant #4 had one incident that required an incident report; however, the incident was not an elopement due to cognitive status and decision making ability. Tenant #4 had another incident after admission; however, it did not require an incident report or reporting to the Department.

- Regulatory Insufficiency: None noted.