IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 37584-I

February 9, 2012

Ms. Brenda Cook, Director
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

RE: Final Complaint/Incident Investigation Report – Senior Star at Elmore Place, Davenport, IA

Dear Ms. Cook:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 30, 2012, 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

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

Assisted Living Program:

Complaint/Incident Intake #: 37584-I

Brenda Cook, Director of Assisted Living
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

Date of Complaint/Incident Investigation:

January 30, 2012

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	63
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	64
TOTAL census of Assisted Living Program	64

Program History – There were substantiated Regulatory Insufficiencies found during this certification period for Service Plan, Medications and Nurse Review.

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

A. Other

Complaint/Incident Allegation: The Program reported a tenant left the building, walked across the parking lot and attempted to enter another building. It was reported the tenant was dressed in day time clothes, jacket and unconnected oxygen tubing. It was reported the tenant was immediately returned to the building, was assessed and did not have any injuries.

- Monitoring Observation: Tenant #1, a 79 year old, was admitted on 12-20-11 and diagnoses include Dementia (Alzheimer's Type), Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Anxiety, Hypertension, Gastric Esophageal Reflux Disease, Pulmonary Fibrosis and Hyperlipidemia. Tenant #1 scored a 24/29 on the Folstein Mini Mental Exam (MMSE) completed on 1-18-12 which indicated normal to very mild impairment. According to the service plan, Tenant #1 ambulated without assistive devices. Tenant #1 used two liters of oxygen continuously.

  The Program is located on a campus that included an independent living building, a dementia specific building and the Program, which was the assisted living building. The dementia specific building was directly across the parking lot from the assisted living building.

  According to an Incident Report, on 1-20-12 at 12:45 a.m. Tenant #1 was found at the front door of the dementia specific building. Tenant #1 was dressed in clothes, coat and had oxygen on. Tenant #1 stated he/she just wanted to get out of the apartment. No injury was noted. Tenant #1 was aware that it was winter and it was the middle of the night. The Assistant Director of Nursing (ADON) was notified. Tenant #1's family member and doctor were notified.

According to a Nursing Note completed on 1-20-12, the ADON was notified on call at 12:45 a.m. that at 12:00 a.m., Tenant #1 had a two hour check completed and Tenant #1 was awake and in bed. At 12:45 a.m., Staff #1 received a phone call from the dementia specific building across the parking lot that a tenant was knocking on the front door of the building. Staff #1 went out of the building and across the parking lot to see what was going on. She saw Tenant #1 knocking on the door. Tenant #1 was dressed in day time clothes, a jacket and unconnected oxygen tubing. Tenant #1 stated he/she just wanted to get out of the apartment. Staff #1 ushered Tenant #1 back into the building and assessed Tenant #1. No injuries were noted. Staff #1 again asked Tenant #1 what he/she was doing outside the building? Tenant #1 stated he/she wanted to get out of the apartment. Tenant #1 was brought back to his/her apartment and settled in for the night. Staff #1 notified the ADON of the event. The ADON directed staff to increase the frequency of rounds to hourly. Staff #1 notified Tenant #1's family member.

Cognitive, health and functional evaluations were completed on 1-20-12 after Tenant #1's elopement. Tenant #1's cognitive score had declined. The MMSE score was 22/29 and Tenant #1 was staged at a three on the Global Deterioration Scale which indicated mild cognitive decline. Tenant #1's service plan was updated on 1-20-12 and reflected a change in cognitive status and assessment for possible placement in a dementia specific program. Interventions reflected needs for safety monitoring due to wandering and required escorts at all times outside of apartment.

Staff #1, a Licensed Practical Nurse (LPN) said she was in the north end medication room and received a call from the dementia specific building that a tenant was at the front door of the dementia specific building. She stated the call came over the pager and she and Staff #2 heard it at the same time and ran to the lobby. Staff #1 stayed in the building and sent Staff #2 to the dementia specific building to assist Tenant #1. She stated Staff #2 asked Tenant #1 who he/she was and Tenant #1 responded correctly. Tenant #1 was wearing a coat, clothes, shoes and oxygen. Thirty minutes earlier Staff #2 had checked on Tenant #1 who was in his/her bed and was wearing pajamas. When Tenant #1 was asked why he/she went outside, Tenant #1 stated he/she wanted to get out of the apartment for awhile. Staff #2 walked Tenant #1 back to his/her apartment and helped Tenant #1 put on pajamas and go back to bed. Staff #1 checked on Tenant #1 every hour for the remainder of the shift and Tenant #1 stayed in bed the rest of the night. Staff #1 called the ADON right after the incident happened to report the incident. Staff #1 stated Tenant #1 did not have any previous elopements. Staff #1 stated it was a cold night, maybe 15 degrees outside. She stated the situation was handled appropriately.

Staff #2 stated Tenant #1 was on two hour checks. Staff #2 went into Tenant #1's apartment and Tenant #1 was in bed, was awake and she spoke with Tenant #1 at approximately 12:05 a.m. Staff #2 completed the rest of her rounds. At approximately 12:30 a.m., she received a page from dementia specific staff stating they had a tenant from the assisted living building. Staff #2 stated the front door locked after anyone exited and you could not get back inside the building. Staff #2 stated Tenant #1 wanted to go out for a walk. Staff #2 helped Tenant #1 back to his/her apartment, assisted with putting pajamas on and Tenant #1 stayed in bed the rest of the night.

Staff #2 stated Tenant #1 was wearing sweater, slacks, hat, coat, shoes, and socks when found outside. Staff #2 stated it was cold, no snow and was two degrees below zero. Tenant #1 did not complain of pain but stated his/her hands were ice cold. Staff #2 stated Tenant #1 did not have any previous elopement attempts, or demonstrated any signs of possible elopement. Staff #2 stated the incident was handled appropriately.

The ADON stated she was called at 12:45 a.m. on 1-20-12 from Staff #1 who reported a call came in from the dementia specific building and a tenant was outside their front door. Staff found Tenant #1 knocking on the dementia specific door. The last time Tenant #1 was checked by a staff member was at midnight. Tenant #1 was fully clothed and stated he/she wanted to get out of the apartment. Tenant #1 redirected well. Staff contacted Tenant #1's family member and Tenant #1 was placed on one hour checks. Tenant #1 did not have a history of elopements. The following morning, Tenant #1 was assessed and transferred to a dementia specific program. The ADON stated Tenant #1 was wearing pants, shirt, socks, shoes and a coat. The ADON did not know the temperature but stated it was cold. Tenant #1 did not suffer any injuries from the incident. The ADON stated the situation was handled appropriately.

Staff #1 and the ADON did not identify any tenants who exceeded the appropriate level of care. Staff #1, Staff #2 and the ADON stated there was enough staff to meet the needs of the tenants. The ADON did not identify any other tenants who eloped and stated Tenant #1 had not eloped prior to the incident on 1-20-12.

Tenant #1 was assessed on 1-20-12 by a dementia specific program. Family was notified and chose to transfer to a dementia specific program. Tenant #1 was transferred to a dementia specific program at 12:30 p.m. on 1-20-12.

According to the State Climatologist, on 1-20-12 at 12:52 a.m. at the Davenport Airport, the temperature was three degrees; winds were from the east at nine miles per hour and wind chill was -11 degrees.

Tenant #1 eloped on 1-20-12. After the elopement Staff #1, an LPN, assessed Tenant #1 and he/she did not sustain any injuries. Evaluations were completed and the service plan was updated. Tenant #1 did not have a history of elopements. Tenant #1 moved to a higher level of care on 1-20-12. Staff followed the policy and procedures for elopements. The Program reported the incident to the Department and completed an incident report.

- Regulatory Insufficiency: None noted.