IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38824-I

May 24, 2012

Mr. Gary Larew, Administrator
Martina Place Assisted Living
5815 Winwood Drive
Johnston, IA 50131

RE: Final Complaint/Incident Investigation Report, Martina Place Assisted Living, Johnston, Iowa

Dear Mr. Larew:

Enclosed is the **Final Complaint/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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Gary Larew, Administrator
Martina Place Assisted Living
5815 Winwood Drive
Johnston, IA 50131

Complaint/Incident Intake #: 38824-I

Date of Complaint/Incident Investigation:

April 25, 2012

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:	54
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	58
TOTAL census of Assisted Living Program	58

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Evaluation

Complaint/Incident Allegation: The program reported Tenant #1 had eloped from the program on 4-19-12.

- Monitoring Observation: Tenant #1, a 75 year old, was admitted on 7-1-10 with diagnoses of: High Blood Pressure, Dementia, Parkinson's Disease, Mild Dyskinesia and Sundowner's Disorientation. A cognitive evaluation completed on 4-23-12 indicated Tenant #1 scored 28 out of 30, which indicated normal cognition. Functional and health evaluations (as part of a quarterly nurse review) of 12-19-11 indicated Tenant #1 used a cane or walker and was independent with activities of daily living (ADLs). Tenant #1 was administered medications by the program and needed reminders to attend meals and activities.

  A managed risk agreement was established on 8-5-11 due to a fall Tenant #1 sustained when walking alone outside. Tenant #1 agreed to walk with staff and walk in the courtyard, but if Tenant #1 continued to walk alone there were safety risks.

  Program "notes and concerns" (nurse's notes), indicated a wander-guard pendant was placed on Tenant #1 to alert staff if Tenant #1 was having a bad day and felt confused. If the Tenant went in the wrong direction, staff could assist Tenant #1 to where he/she needed to go. Program documentation indicated one wander-guard alarm device was placed on the front door of the program.

  Nurse's notes of 2-2-12 indicated the Tenant had several episodes of confusion and disorientation and wanting to leave the Program. Tenant #1 reportedly wanted his/her car and wanted to go home. Tenant #1's confusion was more severe than in the past. A physician consult report of 2-8-12 indicated Tenant #1 had new diagnoses of Sundowner's Disorientation at times and Mild Dyskinesia.

Nurse's notes of 3-9-12 indicated Tenant #1 tried to get out of the program through the front door. An alarm sounded and Tenant #1 was resistant to staff's direction to step away from the front door. Nurse's notes of the same entry indicated Tenant #1 was later wandering throughout the program.

A 90-day nurse review of 3-15-12 indicated Tenant #1 was wandering and confused, and used the wander-guard..

An incident report of 4-5-12 indicated Tenant #1 had eloped at approximately 4:00 p.m. Staff #1 saw Tenant #1 near the front door. Staff #1 was interviewed and reported he directed Tenant #1 back to his/her room. When Staff #1 returned to Tenant #1's apartment Tenant #1 was not there. Staff looked for Tenant #1 and found him/her outside. Tenant #1 was escorted back inside.

The incident report follow-up directed staff to monitor Tenant #1's activity during the evening and night shift and to increase their monitoring of Tenant #1 during the evening hours when Tenant demonstrated increased confusion.

The State Climatologist gave the following weather conditions for the Des Moines International Airport (closest proximity to the program address) on 4-5-12, at approximately 4:00 p.m.: temperature 51 degrees, northwest wind at 11 miles per hour (mph) with cloudy skies with .002 inches of precipitation.

Nurse's notes of 4-9-12 indicated Tenant #1 was confused in the p.m. and wanted to drive his/her car to a family member's house. A phone call was placed to Tenant #1's family member and Tenant #1 was calmer after speaking with the family member.

An incident report of 4-19-12 indicated Tenant #1 eloped at approximately 6:15 p.m. Staff #1 saw Tenant leave the dining room after supper. Staff #1 reported he received a phone call from another staff that Tenant #1 was seen in the parking lot. Staff went outside and brought Tenant #1 back. Staff #1 reported Tenant #1 told staff he/she was going to his/her car.

The incident report follow-up directed staff to: monitor Tenant #1 and provide a safe environment, provide activities as needed and monitor frequently to ensure safety. All outside doors were locked and were to remain locked until further precautions were in place.

The State Climatologist gave the following weather conditions for the Des Moines International airport (closest proximity to the Program address) on 4-19-12., at approximately 6:15 p.m.: temperature 64 degrees, west wind at 15 to 20 miles per hour (mph) with cloudy skies with .001 precipitation and thunderstorms.

Functional, cognitive and health evaluations were completed on 4-23-12, but evaluations were not completed with a significant change in condition beginning 2-2-12 when increased confusion and disorientation was noted and Tenant #1 wanted to leave the program and eloped

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also

evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.
(IAC r.481-69.22(2))

B. Service Plans

During the course of the investigation, the following information was obtained.

- Monitoring Observation: Tenant #1's service plan of 10-14-11 indicated Tenant #1 was independent with activities of daily living (ADLs), needed reminders for meals and activities, but did not indicate Tenant #1 had a managed risk agreement, established on 8-5-11 and used a wander-guard pendant.

  Nurse's notes of 2-2-12 indicated the Tenant had several episodes of confusion and disorientation and wanted to leave. Tenant #1 reportedly wanted his/her car and wanted to go home. Tenant #1's confusion was more severe than in the past. A physician consult report of 2-8-12 indicated Tenant #1 had new diagnoses of Sundowner's Disorientation at times and Mild Dyskinesia

  Nurse's notes of 3-9-12 indicated Tenant #1 tried to get out through the front door. An alarm sounded and Tenant #1 was resistant to staff's direction to step away from the front door. Nurse's notes of the same entry indicated Tenant #1 was later wandering throughout the program. A 90-day nurse review of 3-15-12 indicated Tenant #1 was wandering, confused, and used the wander-guard.

  An incident report of 4-5-12 indicated Tenant #1 eloped at approximately 4:00 p.m. Staff #1 saw Tenant #1 near the front door .Staff #1 was interviewed and reported he directed Tenant #1 back to his/her room. When Staff #1 returned to Tenant #1's apartment Tenant #1 was not there. Staff looked for Tenant #1 and found him/her outside. Tenant #1 was escorted back inside.

  The incident report follow-up directed staff to monitor Tenant #1's activity during the evening and night shift. Staff was to increase their monitoring of Tenant #1 during the evening hours when Tenant demonstrated increased confusion.

  Nurse's notes of 4-9-12 indicated Tenant #1 was confused in the p.m. and wanted to drive his/her care to a family member's house. A phone call was placed to Tenant #1 family member and Tenant #1 was calmer after speaking with the family member.

  An incident report of 4-19-12 indicated Tenant #1 eloped at approximately 6:15 p.m. Staff #1 saw the Tenant leave the dining room after supper. Staff #1 reported he received a phone call from another staff Tenant #1 was seen in the parking lot area. Staff went outside and brought Tenant #1 back. Staff #1 reported Tenant #1 told staff he/she was going to his/her car.

An addendum to the service plan was added on 4-20-12. Interventions were established related to Tenant #1's elopement of 4-19-12 which included: escorting Tenant #1 when out of the building, frequent surveillance during evening and sleeping hours, offering to escort Tenant #1 when walking outside and offering use of the courtyard. The service plan addendum was not supported by evaluations.

The incident report follow-up directed staff to: monitor Tenant #1 and provide a safe environment, provide activities as needed and monitor frequently to ensure safety. All outside doors were locked and were to remain locked until further precautions were in place.

The service plan was updated on 4-23-12, after the elopement of 4-19-12 but not with a significant change in condition beginning 2-2-12 through 4-19-12. The service plan of 4-23-12 did not include information related to the managed risk agreement and the use of the wander-guard system.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r.481-69.26(1))

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30-days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))