IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 39370-I
39434-C

July 27, 2012

Ms. Jennifer Stohl, Facilities Director
The Fountains Assisted Living
3752 Thunder Ridge Road
Bettendorf, IA 52722

RE: Final Complaint/Incident Investigation Report, The Fountains Assisted Living, Bettendorf, Iowa

Dear Ms. Stohl:

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 Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

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:

Jennifer Stohl, Facilities Director
The Fountains Assisted Living
3752 Thunder Ridge Road
Bettendorf, IA 52722

Complaint/Incident Intake #: 39370-I
39434-C

Date of Complaint/Incident Investigation:

June 18 & 19, 2012

Monitor(s):

Stephanie Cummins, MA
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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	32
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	49
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	14
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	63

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

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

A. Staffing

Complaint/Incident Allegation #39434-C: It was alleged a number of tenants required an assistive device for mobility and required more assistance. It was alleged there was not enough staff to meet the increased care needs and supervision. It was alleged a staff member was injured while on duty due to water on the floor and was sent home which left one staff member on duty.

- Monitoring Observation: The Program consisted of a dedicated dementia unit (secured dementia unit) and a population that was dementia specific by definition (assisted living).

  According to a Program document, 12 of the 14 tenants in the secured dementia unit used an assistive device including a walker or wheelchair. The range of assistance with mobility included independent with assistive devices, stand by assistance and staff assistance.

  Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed and did not reveal any level of care concerns related to mobility.

  The Program's Staffing Policy indicated a dementia-specific program shall have one or more staff persons who monitor tenants as indicated in the service plan.

The staff shall be awake and on duty 24 hours in the proximate area, and check on tenants as indicated in the tenants' service plans.

The ALP Entrance Form indicated two staff members were assigned to the secured dementia unit on first and second shifts and one staff member on third shift. Schedules for the past three months were reviewed and consistently indicated two staff members were assigned on first and second shifts and one staff member on third shift in the secured dementia unit.

One family member and one guardian were interviewed. There were no concerns regarding tenant cares and services. There were no concerns regarding staffing.

Staff #1 said there was enough staff and tenants received all the cares they required. Staff #2 said there was not enough staff; however, she said tenants received all the cares they required. She said the week days were okay because an activity person was there on Monday, Tuesday and Thursday but on the weekends there was only two staff.

The Director of Nursing (DON) said there was enough staff and tenants received all the cares they required. The Facilities Director said there was enough staff to meet the needs of the tenants.

According to an Employee Accident and Incident Report, on 6-9-12 at 7:30 p.m., Staff #5 fell in a puddle of water in the whirlpool room and was injured. The Facilities Director said the staff member worked until 9:00 or 9:30 p.m. and then went to the Emergency room. She said no tenants were injured. She said there was a faulty sprinkler head and maintenance found the leak.

The DON said if a staff member had to leave or was unable to perform tasks, a variety of things could be done including to pull a staff from assisted living, call a staff member to come in or the DON or the Assistant Director of Nursing (ADON) would cover.

Staff #1 said if a staff member had to leave or was unable to perform tasks, staff would call via a two way radio to assisted living and a staff member or management would come and help. Staff #2 said if a staff member had to leave or was unable to perform tasks the next shift picked up things that were unable to be done and someone would be sent from assisted living so there would always be two staff.

There were no tenant injuries related to the sprinkler head leak in the shower room. Interviews indicated coverage would be provided if a staff member left or was not able to complete tasks. Review of Program documents and interviews indicated there was enough staff to meet the needs of the tenants.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #39434-C: It was alleged a tenant fell and there was a concern regarding nursing supervision.

Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

Incident Reports for the past three months were reviewed. Tenants #2, #3, and #5 had falls.

Tenant #2, a 93 year old, was admitted on 4-30-12 and diagnoses include: Hypertension (HTN), Gastro Esophageal Reflux Disease, Permanent Pacemaker, Dementia, Anxiety, Depression, Renal Insufficiency, Lymphoma and Hyperlipidemia. Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #2 resided in the secured dementia unit. There were several incident reports related to Tenant #2 being found on the floor. On 5-1-12, Tenant #2 was found on the floor and Tenant #2 had redness on the right shoulder and a scratch on the right knee. On 5-17-12, Tenant #2 was found on the floor and had a skin tear to the left arm. Incident reports were completed related to the incidents, the physician was notified and nurse reviews were completed. The service plan identified a fall history and interventions related to the falls.

Tenant #3, an 88 year old, was admitted on 9-22-06 and diagnoses include: Alzheimer's Disease, HTN, Hashimoto's Disease, Hyperlipidemia, Hypothyroidism and Anxiety. Tenant #3 was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive decline. Tenant #3 had two incident reports in the past three months related to falls. According to an Incident Report on 5-21-12 at 2:30 a.m., Tenant #3 was found sitting on the floor beside the bed on Tenant #3's left hip and elbow. There was redness noted on Tenant #3's left elbow. Tenant #3 did not complain of pain. According to an Incident Report on 6-9-12 at 8:15 p.m., Tenant #3 was walking with a family member down a hallway and Tenant #3 fell. Tenant #3 had a bruise and skin tear on the right elbow. Tenant #3 did not complain of pain. Ice was applied to the elbow and steri-strips on the skin tear. Incident reports were completed with the falls, the physician was notified and nurse reviews were completed. The service plan indicated Tenant #3 was independent with ambulation and did not require any assistive devices.

Tenant #5, a 94 year old, was admitted on 1-12-11 and diagnoses include: HTN, Osteoarthritis, Psoriasis, Hyperlipidemia and Depression. Tenant #5 was staged at a five on the GDS, which indicated moderately severe decline. Tenant #5 resided in the secured dementia unit. Tenant #5 had several incident reports in the past three months regarding falls. According to an Incident Report, on 6-9-12 at 8:30 a.m. Tenant #5 was found in the bathroom doorway heading toward the bed. Tenant #5 did not complain of pain and had a left knee abrasion and skin abrasions on both elbows and upper left back. Incident reports were completed with the falls, the physician was notified and nurse reviews were completed. The service plan identified physical therapy worked with Tenant #5 approximately twice a week for gait and transfer training and strength and balance.

One family member and one guardian were interviewed. There were no concerns regarding tenant cares and services. There were no concerns regarding staffing.

Staff #1 said there was enough staff and tenants received all the cares they required. Staff #2 said there was not enough staff; however, she said tenants received all the cares they required. She said the week days were okay because an activity person was there on Monday, Tuesday and Thursday but on the weekends there was only two staff.

The DON said there was enough staff and tenants received all the cares they required. The Facilities Director said there was enough staff to meet the needs of the tenants.

Review of incident reports and tenant files indicated several tenants had fallen or were found on the floor. None of the tenants reviewed had a significant injury related to the incidents. Nurse reviews were completed related to the incidents, interventions were listed if needed and the physicians were notified. Interviews indicated there was enough staff to meet the needs of the tenants.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #39434-C: It was alleged a tenant was not clean and there was a concern it happened more frequently.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #2's file was reviewed. The service plan reflected one staff was to assist Tenant #2 with hygiene and Tenant #2 required assistance with combing hair, setting up toothbrush and verbal cueing to brush teeth. Tenant #2 was observed and appeared neat and clean.

  Tenant #3's file was reviewed. The service plan reflected one staff was to assist Tenant #3 with hygiene. Family and staff assisted Tenant #3 with brushing upper denture. Tenant #3 was observed and appeared neat and clean.

  Tenant #4, a 92 year old, was admitted on 9-2-06 and diagnoses include: Anxiety, Alzheimer's Dementia, Peripheral Edema, Depression, Osteoporosis and Hypokalemia. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #4 resided in the secured dementia unit. The service plan reflected one staff was to assist Tenant #4 with hygiene. Staff to ensure Tenant #4 washed hands before meals and frequently during waking hours. Tenant #4's hands were to be checked for cleanliness after toileting and several times during waking hours on each shift. Tenant #4 was observed and appeared neat and clean.

  The tenant files reviewed did not reveal concerns with hygiene or cares not completed. The monitors observed tenants in the secured dementia unit after a meal and the tenants appeared neat and clean.

  One family member and one guardian were interviewed. There were no concerns regarding tenant cares and services. There were no concerns regarding staffing.

Staff #1 said there was enough staff and tenants received all the cares they required. Staff #2 said there was not enough staff; however, she said tenants received all the cares they required. She said the week days were okay because an activity person was there on Monday, Tuesday and Thursday but on the weekends there was only two staff.

The DON said there was enough staff and tenants received all the cares they required. The Facilities Director said there was enough staff to meet the needs of the tenants.

Review of tenant files did not reveal concerns with cares or services. Tenant observations indicated tenants appeared to be neat and clean. Interviews indicated there was enough staff to meet the needs of the tenants.

- Regulatory Insufficiency: None noted.

B. Service Plans

Complaint/Incident Allegation #39434-C: It was alleged a tenant wandered into other tenants' apartments when not supervised.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed. Tenant #2's file indicated there were behaviors including pacing and going into other tenant apartments. Staff #1 said Tenant #2 wandered into other tenant apartments. She said staff redirected Tenant #2 back to Tenant #2's apartment.

~~Tenant #2's file was reviewed. According to Clinical Notes dated 5-7-12, a fax was~~ sent to the attending physician regarding Tenant #2's anxiety and pacing around the Program constantly and yelled for help. Lorazepam 0.5 mg by mouth twice daily was ordered. The Clinical Notes dated 5-10-12 indicated Lorazepam 0.5 mg by mouth three times daily as needed was ordered. The service plan reflected Tenant #2 had a negative mood, anger and made negative statements. The service plan also reflected Tenant #2 yelled for help, went door to door looking for a way out. Tenant #2 would try to get into other tenant apartments and go through other tenants' personal items. The interventions listed included to assist with activities to help keep busy, offer a snack, redirect Tenant #2 back to the apartment, remove from the situation or take on a walk. Other interventions included Tenant #2 received as needed Lorzepam, provide a calm environment, redirect, distract with food or other activities, according to the service plan.

Tenant #2 was a new admission with moderately severe cognitive decline that resided in the secured dementia specific unit. Tenant #2 had medication changes and the service plan identified behaviors and provided interventions regarding the behavior.

- Regulatory Insufficiency: None noted.

C. Life Safety

Complaint/Incident Allegation #39370-I: The Program reported a tenant from the secured dementia unit joined an activity in assisted living. The tenant was last seen approximately five minutes prior in the tenant's apartment. The tenant was not witnessed outside and was not seen entering assisted living from the outside at any time by any staff members. The tenant was assisted by staff back to the secured dementia unit after the activity was completed.

- Monitoring Observation: Tenant #1, an 85 year old, was admitted on 2-1-10 and diagnoses include: Alzheimer's Disease, Congestive Heart Failure and Probable Cardiomopathy. Tenant #1 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #1 resided in the secured dementia unit. Tenant #1 had moved from the assisted living to the secured dementia unit on 5-14-12. A new occupancy agreement was signed. Cognitive, health and functional evaluations were completed and a service plan was developed. The service plan indicated Tenant #1 was independent with ambulation.

  According to an Incident Report, on 5-20-12 at 2:35 p.m. Staff #3 called from a two way radio from assisted living and asked staff in the secured dementia unit if they were missing a tenant. They told her they did not think so and started checking. Tenant #1 was in the assisted living side having cookies and lemonade. Less than five minutes before Staff #3 called staff in the secured dementia unit, Tenant #1 was taking pictures from Tenant #1's wall and putting them on dining tables. There were no visible changes or injuries noted. The ADON and Tenant #1's physician and family were notified.

After the incident with Tenant #1, cognitive, health and functional evaluations were completed and the service plan was updated. The service plan reflected Tenant #1 required an escort when out of the secured dementia unit and to check on Tenant #1 hourly and as needed during transition. Hourly check documentation was reviewed and checks were consistently documented.

According to a Program document, Tenant #1 joined an activity in the common area in assisted living with activity staff and other tenants on 5-20-12 at approximately 2:35 p.m. Tenant #1 was last seen on 5-20-12 at approximately 2:30 p.m. in Tenant #1's apartment by Staff #1 and Staff #2. Tenant #1 was not witnessed outside by any staff members and was not seen entering assisted living from the outside at any time by staff members. A door alarmed at approximately 2:29 p.m. in the secured dementia unit for the west exit door. Staff at that time checked the door and did not witness any tenants leaving the Program. Tenant #1 was seen by Staff #3 at approximately 2:35 p.m. participating in an assisted living activity in the front common area. At that time Staff #3 stayed with Tenant #1 while Tenant #1 ate cookies and drank lemonade and notified the secured dementia unit staff that Tenant #1 was at the assisted living activity. Staff had thought Tenant #1 was brought to the building by Tenant #1's family member and taken to the activity. When Tenant #1 was asked if Tenant #1's family member was there, Tenant #1 responded "no." Tenant #1 said Tenant #1 wanted to come and visit friends. A staff member assisted Tenant #1 back to Tenant #1's apartment after the activity was finished. Tenant

#1 had previously lived in the general population of the assisted living and moved to the secured dementia unit on 5-14-12.

The Alarmed Doors/Delayed Egress Door policy was reviewed. It was to ensure that each tenant was safe and to maintain the secured dementia unit as a locked unit. All doors leading to the outside were delayed egress doors, including the two doors leading to each courtyard, the front entrance to the building and the back entrance to the building. The only way to enter the building through those doors was to enter the correct code into the keypad located next to the door. There were two ways to exit the building through those doors, to put in the correct code into the keypad next to the door. The door would unlock and after it closed, would once again be locked after a short delay. The other way to exit was to push on the door for a minimum of three seconds, and after 15 seconds the door would unlock and the alarm would sound. Each time the door was opened in that manner, the lock must be reset. On the door handle was a green light. When there was a blinking green light or no light the door was not alarmed. If a door alarmed, staff was to immediately perform a physical check of each tenant in the Program to ensure tenant safety and to ensure that no tenants had exited through the alarmed door. Staff was to make sure all alarmed/delayed egress doors were functional and alarmed with the light on green at each change of shift. If noted a door alarm was not functioning correctly, staff would notify the supervisor and the door would remain in staff's vision at all times until it could be repaired.

Security check documentation for the doors was reviewed. The security checks were documented as completed on 5-20-12.

The east and west doors had an interior exit door that led to a small hallway which led to an exterior delayed egress door and then outside. The interior exit doors for the west exit and east exit were the only alarms that sent pages through the computer system and to staff pagers. The other door alarms were audible. Door alarm records were provided for 5-20-12 for the secured dementia unit. The records indicated on 5-20-12 at 2:29 p.m. the west exit door alarmed and was reset at 2:29:12.

Staff #1 had a Witness Statement and was also interviewed. Staff #1 indicated earlier in the day staff heard the alarm go off and responded. The door also showed on the pager. Tenant #1 was redirected. Staff #1 said Staff #2 turned the key, it clicked and was green. The alarm went off so the key was returned and pushed on the handle. Staff then went back to work. Later in the day Tenant #1 unpacked and took all of Tenant #1's pictures off the wall and staff put the pictures back. Staff #1's two way radio went off and Staff #3 asked if they were missing someone and she had someone eating cookies and lemonade. Staff #1 walked around the secured dementia unit, did a head count and Tenant #1 was missing. Staff #1 went to get Tenant #1. Staff #3 told Staff #1 she would stay with Tenant #1 until Tenant #1 was done eating and would bring Tenant #1 back. All exit doors were rechecked and were locked. The northwest exit door had a green light but it wasn't sounding or locking. Staff #1 called Staff #4 and Staff #2 called the ADON. Staff #1 said the pager did not reflect any messages and she did not hear any alarms. Staff #1 said Tenant #1 did not sustain any injuries, there had been no previous or subsequent elopement attempts and the situation was handled appropriately.

Staff #2 had a Witness Statement and was also interviewed. Staff #2 indicated on 5-20-12 at 10:00 a.m. Tenant #1 went through the first door and the door alarmed and staff redirected. At 2:35 p.m. staff called via two way radio that Tenant #1 was up front. Less than five minutes prior Tenant #1 was taking pictures off the wall in Tenant #1's apartment. Staff #2 said Staff #1 had the pager and at the time there was one pager and now there were two pagers. Staff #2 called the ADON and Staff #1 called Staff #4. Staff #2 said Staff #1 went to recheck the door and it didn't alarm. Staff #2 said staff watched the doors, were not close to it but paid attention to the west door. Staff #2 said Tenant #1 had not been exit seeking prior to that day. Staff #2 said the west door exit was sent to the pager and Staff #1 had the pager. Staff #2 said Tenant #1 was seen within five minutes before Tenant #1 was found. Staff #2 said Tenant #1 did not sustain any injuries, there had been no previous or subsequent elopements and the situation was handled appropriately.

Staff #3 had a Witness Statement and was interviewed. Staff #3 indicated she saw a page for the secured dementia unit west door before she went to lunch and saw it was cancelled. She came back from break about 2:00 p.m. and was standing at the computer and saw Tenant #1 pass the desk to the common area for cookies and lemonade. She thought a family member dropped Tenant #1 off at the front door. Staff #3 asked Tenant #1 where was Tenant #1's family member and Tenant #1 said Tenant #1's family member was not there. Staff #3 then called via two way radio to the secured dementia unit to see if they were missing someone. Tenant #1 was eating cookies and drinking lemonade and would not go back with staff so staff stayed with Tenant #1 until second shift took Tenant #1 back. Staff #3 said Tenant #1 did not sustain any injuries.

Staff #4, the Maintenance Director, had a Witness statement and was interviewed. Staff #4 was notified between approximately 2:45 p.m. and 3:15 p.m. on 5-20-12 regarding the secured dementia unit door would not lock. Staff #4 asked staff if the door was getting power and asked if staff had checked the breaker to see if the breaker was tripped. Staff said the door had power and they had checked the breaker and it was fine. Staff #4 arrived at the Program at approximately 4:00 p.m. The door was armed but the mechanical door was not locked. Staff #4 rearmed the door by pushing on it (the crash bar) and it rearmed. It took approximately 30 seconds to fix. Staff #4 called an outside company to repair it and they came out on 5-21-12. The crash bar was taken apart and it was determined the proximity switch was out of place. The door did lock appropriately and alarm on 5-20-12. Staff #4 said in the secured dementia unit the west and east interior doors went to the computer and to staff pagers. The north, west, east exit doors, courtyard door and entrance were delayed egress doors and were audible but did not go to staff pagers. Staff #4 got a call that the west exit door had a green light but one could walk right through it. Staff #4 said he came in within 15 minutes and it was reset. Staff #4 called an outside company to repair it and they were out the next day. The push bar was taken apart and the proximity switch was repaired. The company was called out a second time; however, the issue with the door could not be duplicated.

The ADON had a Witness Statement. Staff #2 called the on-call phone on 5-20-12 at 2:44 p.m. Staff #2 could not reset the secured dementia unit door and Tenant #1 had gotten out earlier, made it through the front door and was found up front. They were not able to lock the door to reset it. The ADON instructed staff to call Staff #4.

After the incident with Tenant #1, staff had a one on one in-service on door pages and protocol. There was also an in-service training on door alarms and how to disarm and rearm the security doors.

Staff #4 tested the doors and door alarms with the monitors present. The interior west exit door functioned appropriately and sent a message to a staff pager when it was opened. The west exterior exit door was a delayed egress door. After it was opened the door did not rearm appropriately and Staff #4 said it was the switch. Staff #4 rearmed the door and called an outside company to come out.

An invoice from the outside company that worked on the door was provided. The service date was listed as 5-22-12 and it indicated the back panic bar of the secured dementia unit was worked on. There was no invoice for the second call for service as there was no charge. The company was called on 6-18-12 to come back out to repair it.

The monitors walked outside from the front entrance of the Program to the west exit door of the secured dementia unit and it took between 50-55 seconds to walk the distance and it was approximately 78 steps. There was a concrete sidewalk from the west exit door of the secured dementia unit to the front entrance of the Program.

According to the State Climatologist, on 5-20-12 at 2:00 p.m. the temperature was 82 degrees, humidity was 45%, winds were from the west gusting to 30 miles per hour (mph) and it was mostly cloudy. On 5-20-12 at 3:00 p.m. the temperature was 84 degrees, humidity was 40 %, winds were from the west gusting to 30 mph and there were few clouds. There was no rain on 5-20-12.

An incident report was completed related to the incident and the Program reported it to the Department appropriately.

The west exterior delayed egress door did not function appropriately on 5-20-12 and did not function appropriately when checked on 6-18-12 as part of the investigation. Tenant #1 resided in the secured dementia unit and was found in assisted living at an activity on 5-20-12 at approximately 2:35 p.m. Staff did not witness Tenant #1 leaving the unit or see Tenant #1 outside. However, at the approximate time when Tenant #1 left the secured dementia unit the interior west exit door alarmed per door records and the exterior west delayed egress door was not functioning appropriately. Tenant #1 was not injured and the time from when Tenant #1 was last seen to when Tenant #1 was found in the assisted living was approximately five minutes. Door alarm records showed the west interior door alarmed at 2:29 p.m. and was reset. Only one staff had a pager at the time of the incident and Staff #1 said there were no pages reflected and there were no audible alarms. Although it could not be determined how Tenant #1 exited the secured dementia unit and was found in the assisted living, during that same time a door in the secured dementia unit was not functioning appropriately and did not function when tested as part of the investigation.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: Written procedures regarding alarm systems and appropriate staff response when a tenant's service plan indicates a risk of elopement or a tenant exhibits wandering behavior. Written procedures regarding appropriate staff response if a tenant with a cognitive disorder or dementia is missing. (IAC r. 481-69.32(2)(a-b))