IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 39870-I

July 31, 2012

Ms. Julie Waterman, Administrator
Vintage Hills at Prairie Trail Assisted Living
1275 SW State Street
Ankeny, IA 50023

RE: Final Complaint/Incident Investigation Report – Vintage Hills at Prairie Trail Assisted Living, Ankeny, IA

Dear Ms. Waterman:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 13, 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 515/281-7039 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: **Complaint/Incident Intake #:** 39870-I

Julie Waterman, Administrator
Vintage Hills at Prairie Trail Assisted Living
1275 SW State Street
Ankeny, IA 50023

Date of Complaint/Incident Investigation:

July 13, 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:	13
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	15

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	23

Program History – The program received a regulatory insufficiency in the area of medications during the May 24, 2012, Initial Certification and Complaint (39194-C) Investigation.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: The program reported Tenant #1 squeezed Tenant #2 in a bear hug, then broke the window jam in his/her apartment and exited through the window. Tenant #1 was outside the Program and walked to an adjacent cornfield. Staff reached Tenant #1 before going into the cornfield and returned Tenant #1 to the Program.

- Monitoring Observation: Tenant #1, an 83 year old, was admitted on 7-1-12 and was diagnosed with a history of Adenocarcinoma of the Pancreas, Alzheimer's Disease, Hyperlipidemia, Hypertension, Internal Hemorrhoids, Parkinson's Disease and Limb Pain. A cognitive evaluation was completed on 7-7-12 and staged Tenant #1 at four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 was first admitted to the general population on 7-2-12, but was later moved to the dementia unit on 7-7-12.

  The Program nurse reported Tenant #1 lived independently prior to moving to the Program. Tenant #1 had a history of wandering while living independently and had a history of vivid dreams. The Program nurse reported she had spoken with Tenant #1's family member and if Tenant #1 wandered or a change in Tenant #1's behavior occurred Tenant #1 could possibly be moved from the general population to the dementia unit.

  Tenant notes (Program's nurse's notes), indicated on 7-6-12, Tenant #1 was uncharacteristically quarrelsome with staff. The Program nurse reported she visited with Tenant #1 the next morning and Tenant #1was laughing, relaxed and had no

memory of his/her earlier behavior. On 7-7-12, night staff found Tenant #1 out of his/her room several times during the night-time hours. Staff reported Tenant #1 did not know the correct time of day during these episodes. The Program nurse spoke to Tenant #1's family member regarding Tenant #1's safety and it was decided to move Tenant #1 to the dementia unit. On 7-11-12, family agreed Tenant #1 would move to the dementia unit.

An incident report of 7-11-12 indicated Tenant #1 woke from a "supper nap" approximately 7:30 p.m., walked to the dementia unit lobby area and physically attacked Tenant #2. The Program nurse reported Tenant #1 "awoke abruptly" and approached Tenant #2 from behind and gave Tenant #2 a "bear hug." Staff intervened and Tenant #1 went to his/her room. Tenant #1's family member was interviewed and reported Tenant #1 had a history of "vivid dreams" and upon wakening, would often act out what he/she was dreaming.

The Program nurse reported she was at the Program on 7-11-12 and had been called down by staff when the incident occurred with Tenant #1 and Tenant #2. The Program nurse reported Tenant #2 sustained no injury from the bear hug Tenant #1 had given Tenant #2.

Tenant notes of 7-11-12, at 7:50 p.m. indicated a tenant, who resided in the dementia unit, reported seeing Tenant #1 outside of the Program. The incident report of 7-11-12 indicated staff and the Program nurse escorted Tenant #1 back to the Program. Tenant #1 told staff "Don't let them get me." Once inside the Program, Tenant #1 was agitated, threw items and walked into other tenants' rooms and held an apartment door shut between him/her and staff.

Tenant notes of 7-11-12 indicated Tenant #1's family took Tenant #1 to a hospital emergency room for evaluation. Tenant #1 returned to the Program at 4:00 a.m. Tenant #1 was cooperative, pleasant and went to bed. At 7:45 a.m. Tenant #1 came out for breakfast, was dressed appropriately, and was smiling and pleasant with other tenants. Tenant #1's service plan was updated on 7-12-12 and included interventions related to Tenant #1's elopement and for hourly safety checks and to leave Tenant #1's apartment door open during the day and evening in order to visually see what Tenant #1 was doing.

Staff LPN #1 and Staff #2 reported Tenant #1's behavior was appropriate upon admission and recalled only one incident of wandering while residing in the general population. After the incident of 7-11-12, Tenant #1 was appropriate, showing no exit seeking or aggressive behavior toward staff or other tenants.

The Program nurse reported Tenant #1 behavior culminated from a reassignment from the general population to the dementia unit and having a history of vivid dreams; often acting out what he/she had dreamt. As of this monitoring visit, Tenant #1 has had no other attempts of elopement or aggressive behavior.

- Regulatory Insufficiency: None noted.