IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 41097-I

October 19, 2012

Ms. Mary Jo Pipkin, Executive Director
Keystone Cedars
6325 Rockwell Drive NE
Cedar Rapids, IA 52402

RE: Final Complaint/Incident Investigation Report – Keystone Cedars, Cedar Rapids, IA

Dear Ms. Pipkin:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 9 & 15, 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

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

Assisted Living Program: **Complaint/Incident Intake #:** 41097-I

Mary Jo Pipkin, Executive Director
Keystone Cedars
6325 Rockwell Drive NE
Cedars Rapids, IA 52402

Date of Complaint/Incident Investigation:

October 9, 2012 & October 15, 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.

General Population Program	
Number of tenants without cognitive disorder:	69
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	69
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	5
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	13
TOTAL census of Assisted Living Program	82

Program History –

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

A. Staffing

Complaint/Incident Allegation: The Program reported staff heard a door alarm while tending to another tenant. Upon entering the common area, staff noticed the emergency exit door was alarming. Staff noticed a tenant was unable to be found in the dementia unit. Staff notified additional staff, which went outside and searched around the building perimeter. Staff also continued to search the dementia unit. The tenant was found walking on the sidewalk up to a locked exit door attempting to get in the building. The tenant was escorted back into the building and had no injuries related to the incident.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1 exited the building on 10-7-12.

  Tenant #1, an 82 year old, was admitted on 9-6-12 and diagnoses include: Hypertension, Atherosclerotic Cardiovascular Disease, Alzheimer's Disease, Depression, Anxiety and Increased Lipids. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. Evaluations and a service plan were developed prior to taking occupancy. The service plan reflected Tenant #1 was independent with mobility and did not utilize an assistive device. The service plan reflected Tenant #1 required an escort outside of the dementia unit. According to a Program record, Tenant #1 had attempted to pack belongings and was redirected to unpack on 10-1-

12. On 10-5-12 Tenant #1 set off front door alarm and was redirected with no problems. On 10-6-12 and 10-8-12 Tenant #1 attempted to get out the front dementia unit doors several times and was redirected.

According to Resident Incident Report (non-fall related), on 10-7-12 at 7:35 p.m. to 7:45 p.m., staff faintly heard a door alarm while tending to another tenant. Upon entering the common area, staff recognized the left hall door alarm was sounding around 7:35 p.m. While doing rounds to determine who was possibly missing, staff noticed Tenant #1 was unable to be found in the dementia unit. Staff walkied for assistance from the assisted living (AL) care staff. Staff continued looking for Tenant #1 in the dementia unit. Two staff from the AL searched the Program's perimeters and found Tenant #1 walking near a locked exit door outside the building. Tenant #1 had previously resided at the Program in the unsecured living area where the ability of coming and going was available when desired and surroundings might have been familiar. Tenant #1 was wearing tennis shoes, jeans, a long sleeve denim shirt, denim jacket and a baseball cap. Staff escorted Tenant #1 safely back into the building and the apartment. Tenant #1 was helped to get ready for bed. Tenant #1 stated Tenant #1 was trying to go home from work. The Director of Health Services was notified at 7:59 p.m. and informed staff to continue to monitor and report any concerns or different behaviors. Tenant #1's family member was notified and the report was faxed to the physician.

Staff #2 said she and Staff #1 were scheduled in the dementia unit when the incident occurred with Tenant #1. They were short one staff in the AL portion and she came out to help answer pages. Staff #1 walkied for assistance and asked Staff #2 to come to the dementia unit right away. Staff #1 had already done rounds twice. Staff #2 and another staff went outside and each went a different direction. Staff #2 found Tenant #1 outside on the front side of the building. Staff #2 said it was not difficult to get Tenant #1 back into the building. Tenant #1 was brought back to Tenant #1's apartment and there were no issues the rest of the shift. Tenant #1 had visual checks and there had been no elopements since the incident.

The Director of Health Services said Staff #1 called her after Tenant #1 was back in the building, around 8:00 p.m. on 10-7-12. Staff #1 told her she was assisting another tenant and as soon as she came up the hall Staff #1 heard the alarm go off. Staff #1 scanned the tenants and realized it was Tenant #1. Staff #1 called two other staff immediately to go outside and check the perimeter. Staff #2 found Tenant #1 outside a front door trying to get into the building. When Staff #2 approached Tenant #1, Tenant #1 followed Staff #2 inside and back to the unit. The Director of Health Services told Staff #2 to make sure all staff knew to keep Tenant #1 within eye shot. Tenant #1 was not hurt and was Tenant #1's normal self. Tenant #1 was appropriately dressed wearing jeans, jacket, ball cap and tennis shoes. There had been no previous attempts to elope but Tenant #1 was an exit seeker since Tenant #1 moved into the dementia unit. She said there had been no further elopement attempts since the incident.

The Staffing Policy indicated the dementia unit would have one or more staff persons who monitored tenants as indicated in each tenant's service plan. All staff would be awake and on duty 24 hours a day in the proximate area, and check on tenants as indicated in the tenants' service plans. Tenants with cognitive disorder or in the

dementia unit would have two hour checks. During the time of the incident one staff remained in the dementia unit and the tenants were not left unattended. The Missing Person Policy was provided and it appeared staff followed the policy regarding the incident with Tenant #1.

According to a Procedure for Egress Exit Memory Care Doors, the dementia unit staff was responsible to check each exit door in the dementia unit at each shift change to ensure they were engaged and operating properly. The checks of the exit doors were completed on 10-7-12 and the exit doors were alarmed and engaged. The door alarm was tested as part of the investigation and functioned appropriately.

A note on Tenant #1's service plan dated 10-5-12 indicated a family meeting for a complete update was scheduled on 10-10-12. A nurse review, cognitive, health and functional evaluations were completed on 10-10-12. A service plan was updated on 10-10-12. The service plan addressed the elopement, exit seeking and Tenant #1 wanting to go home. Tenant #1 was to be kept in eye shot at all times when behaviors were present. Tenant #1 was identified as an elopement risk and staff was to notify nursing if none of the distractions or interventions assisted with decreasing behaviors. Tenant #1 had as needed medication that could be given to reduce anxiety.

The service plan reflected two hour visual checks and provided a sheet of interventions. The behavior interventions related to wandering and exit seeking included to engage Tenant #1 in activities in the dementia unit and various activities were provided. It also indicated if multiple attempts to engage were not working to notify nursing and when behaviors were present staff should at all times have Tenant #1 in eye shot and be able to react to exiting attempts. It also indicated to keep blinds in Tenant #1's apartment in the down position, tilted for light but decreased view of the parking lot and staff was to ensure windows were latched and closed. Visitors were encouraged to visit prior to 2:00 p.m. and within the unit. No outings, other than physician appointments and Tenant #1's family was aware and agreed. The interventions also indicated to monitor behaviors and complete documentation with an increase in exit seeking. It identified Tenant #1 was usually easily redirected to tasks and activities. Staff was to provide reassurance to any verbal concerns. As needed medication was available to decrease anxiety if all other attempts of distractions had been exhausted. The ultimate goal for Tenant #1 was security and safety.

A layout of the Program was obtained. Tenant #1's apartment was located near the exit door that sounded. Tenant #1 was located at a locked door located on the front (not main entrance) of the AL building. It could not be determined the exact path Tenant #1 took as it was not witnessed; however, the possible terrain Tenant #1 might have traveled included concrete sidewalks, an asphalt parking lot and grass. The monitors drove an approximate path Tenant #1 might have traveled and the distance was less than 0.1 of a mile.

According to the State Climatologist, on 10-7-12 at 7:52 p.m. at the Cedar Rapids Airport, the temperature was 35 degrees, wind was from the south at 5 miles per hour, wind chill factor was 31 degrees and clear skies.

An incident report was completed and the Department was notified appropriately.

Per review of tenant files, interviews, review of policies and observations, Tenant #1 exited the building, the alarm functioned and staff responded. A search was conducted and Tenant #1 was located and did not sustain any injuries. Tenant #1 was dressed appropriately and was redirected into the building. Tenant #1 had lived in the AL portion of the Program previously and had no previous or subsequent elopements. While a search for Tenant #1 was conducted the Program was not left unattended. The service plan was updated and reflected various interventions to reduce exit seeking behaviors.

- Regulatory Insufficiency: None noted.