IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 41158-I

October 25, 2012

Ms. Carla Popp, Director
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

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

Dear Ms. Popp:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 16, 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 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: **Complaint/Incident Intake #:** 41158-I

Carla Popp, Director of Memory Care
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

Date of Complaint/Incident Investigation:

October 16, 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 Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	19
Total Population of Program at time of on-site	20
TOTAL census of Assisted Living Program	20

Program History – The program received Regulatory Insufficiencies in the areas of Dementia Specific Education, Nurse Review, Service Plan, Evaluation, Criteria for Retention and Admission, Program Reporting, Policies and Procedures, Tenant Documents and Structural Requirements during this certification period.

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 a tenant activated the alarm system while exiting the front doors of the building. Staff immediately responded and redirected the tenant back into the building. There was no harm to the tenant.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1 had exited the front doors of the building.

  Tenant #1, a 73 year old, was admitted on 10-5-12 and diagnoses include: Dementia, Manganese Toxicity, Hernia, Gastro Esophageal Reflux Disease, Arthritis, Migraines, Hypothyroid, and History of Skin Cancer. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe decline. A document in Tenant #1's file indicated Tenant #1 was a high exit risk. The cognitive evaluation was completed by the Director, a health professional, on 10-3-12. The Resident Assessment was completed on 10-3-12 and the form indicated the Charge Nurse/LPN completed the evaluation. The Director signed the evaluation on 10-5-12. The service plan dated 10-5-12 did not reflect the high exit risk. The service plan reflected Tenant #1 was able to walk without assistive devices.

  According to an Incident Report, on 10-10-12 at 11:55 p.m. the alarm sounded for the front exit and Tenant #1 had made it out of both front doors. Staff went to bring Tenant #1 back in and Tenant #1 came in with no problem. Staff took Tenant #1 to Tenant #1's apartment and checks were completed every 30 minutes. Tenant #1's physician and family member were notified. The Incident Report did not indicate any injuries to Tenant #1.

Tenant #1's Nurse's Notes dated 10-11-12 at 8:00 a.m. indicated Tenant #1 eloped through the front doors and staff responded to the wander alert system on 10-10-12 at 11:55 p.m. Tenant #1 was found outside the second set of doors. Tenant #1 was escorted back into the building without problem. Tenant #1 was placed on 30 minute rounds for the remainder of the shift. There were no other elopements for Tenant #1 in the Nurse's Notes or incident reports.

Records for Tenant #1's rounds were reviewed. Tenant #1's checks were consistently documented as completed hourly and after Tenant #1 left the building checks were consistently completed every 30 minutes for the rest of the shift.

According to the Program's self report, Staff #1 was in the back medication room when the pager went off and read delay egress front door. Staff #1 immediately headed for the front door, which was on the other side of the building. As Staff #1 got towards the front of the building she saw Tenant #1 going out the front door of the building. Staff #1 called Tenant #1's name, Tenant #1 turned to look at Staff #1 and took Staff #1's hand. Staff #1 got Tenant #1 back inside and then to bed. Staff #1 said at the same time this occurred Staff #3 was just coming into work and saw Tenant #1 going outside and Staff #1 and Staff #2 coming to get Tenant #1. There were wet floor barricades in front of the door but Tenant #1 still went out. Tenant #1 did not sustain any injuries and was redirected back into the building.

A layout of the Program was obtained. It indicated the location of the medication room and the door Staff #1 went through to walk through the courtyard. It also showed where Staff #1 walked through another door and reached the lobby and the set of double doors that exited the building, reaching Tenant #1.

The Charge Nurse/LPN was interviewed. She said when she arrived at work on 10-11-12, she found an incident report in the back medication room regarding Tenant #1's incident. She charted in Tenant #1's file and gave the incident report to the Director. Later that day, the second shift nurse sent a fax to the physician. The Charge Nurse/LPN spoke to the physician regarding Tenant #1's medications. The physician declined to change any medications at the time. The Charge Nurse/LPN said there were no further attempts to exit by Tenant #1 as far as she knew.

The Director was interviewed. She said the incident happened on a Wednesday night around midnight. She was the nurse on call and staff did not notify her of the incident. The next morning around 11:00 a.m., the Charge Nurse/LPN told the Director about the incident. She instructed staff to keep a close eye on Tenant #1 and to complete one hour rounds. The Director made rounds two times per day on the unit. The Director instituted monthly staff meetings regarding safety items. She directed staff to keep caution tape and wet floor signs on the exit doors 24 hours per day. She also sent staff a memo on 10-14-12 that included elopement comments. The Director stated she felt the incident was handled appropriately because staff dropped everything and calmly got Tenant #1 back into the building. The Director said she felt Tenant #1 was an appropriate admission as Tenant #1 would never be able to get out of the Program's interior courtyard, plus the way the building was laid out. Tenant #1 would walk around in a square formation.

The Charge Nurse/LPN and the Director said there was enough staff to meet the needs of the tenants and there were no tenants who exceeded the level of care.

The Staffing Guidelines policy indicated the Program maintained a staffing ratio that allowed the Program to most effectively provide quality care services that met the residents' care needs and helped to ensure safe evacuation in an emergency.

The Elopement of Residents policy was provided. It stated all staff members would respond immediately to door alarms and locate the resident that had wandered outside and direct the resident back inside. Staff followed the policy regarding the incident with Tenant #1.

According to the State Climatologist, at 11:52 p.m. on 10-10-12 at the Davenport airport, the temperature was 35 degrees with a wind chill of 29 degrees, winds from the south at 8 miles per hour and clear skies.

An incident report was completed related to the incident and the Department was notified of the incident.

Per review of tenant files, interviews, review of policies and observations, Tenant #1 exited the building, the pager system functioned and staff responded. Tenant #1 was located outside the front doors, was redirected back into the Program and did not sustain any injuries.

- Regulatory Insufficiency: None noted.