IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 41471-I

November 15, 2012

Ms. Jill Boss, RN Director
Maggie's House
107 East 2nd Street
DeWitt, IA 52742

RE: Final Complaint/Incident Investigation Report – Maggie's House, DeWitt, IA

Dear Ms. Boss:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of November 8, 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 #:** 41471-I

Jill Boss, RN Director
Maggie's House
107 East 2nd Street
DeWitt, IA 52742

Date of Complaint/Incident Investigation:

November 8, 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:	17
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	18

Program History – The program received regulatory insufficiencies in the areas of Record Checks during this certification period.

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

A. Service Plan

Complaint/Incident Allegation: The Program reported a tenant walked out of the Program and was going to a family member's house. The tenant was upset about something that another tenant had said. Another tenant watching television reported the elopement to staff. One staff was vacuuming and one staff was using a hair dryer to defrost a freezer and did not hear the doorbell. Staff found the tenant across the street half a block away. The tenant did not have any injuries.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1 had eloped from the Program on 11-4-12.

  According to an Incident/Unusual Occurrence Report dated 11-4-12 at 3:15 p.m., Staff #1 was cleaning a refrigerator for a tenant when Tenant #3 reported Tenant #1 had left and was down the street. Staff #1 went and brought Tenant #1 back. The report indicated Tenant #1 was headed north on 2nd Street. Tenant #1 wanted to go to a family member's house because Tenant #1 was upset with another tenant.

  Tenant #1, an 88 year old, was admitted on 3-27-11 and diagnoses included: Hypertension (HTN), Dementia and Enlarged Heart. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1's service plan indicated Tenant #1 ambulated with a wheeled walker. The service plan dated 9-7-12, prior to the elopement, indicated Tenant #1 at times said Tenant #1 was going to a family member's house and Tenant #1 could walk there. Staff was to redirect Tenant #1 and Tenant #1 was easily redirected.

The service plan dated 9-7-12 indicated Tenant #1 was pleasant and cooperative but did get upset, tearful if having periods of increased confusion and staff was to give emotional support and was to visit with Tenant #1. According to review of Tenant #1's file a nurse review and cognitive, health and functional evaluations were completed on 11-5-12 after the elopement. The service plan was updated on 11-5-12, after the elopement and reflected 30 minute checks for three days and then two hour checks. The service plan indicated when staff heard the doorbell staff was to check where Tenant #1 was located and check the door. Review of the safety check documentation indicated the checks were consistently completed every 30 minutes.

Tenant #2, an 84 year old, was admitted on 1-18-11 and diagnoses included: Dementia, Cerebral Vascular Accident, Urinary Tract Infection, Dehydration, Atrial Fibrillation, HTN and Fractured Right Femoral Head on 3-5-12. A service plan dated 5-24-12 did not reflect a history of negative encounters with staff or other tenants. A nurse review completed on 8-28-12 reflected Tenant #2 visited with tablemates and Tenant #2 had befriended other tenants and they spent time sitting and visiting, sometimes out on chairs on the front porch. The nurse review stated Tenant #2 was almost always smiling.

Staff #1 had a written statement and was interviewed regarding the incident with Tenant #1. She had punched out and had gone into another tenant's apartment defrosting a refrigerator with a hair dryer when Tenant #3 came in and said Tenant #1 had left the Program and was heading north down 2nd Street. Staff #1 told Tenant #3 to find the staff on duty at the time and she ran outside to find Tenant #1. Staff #1 found Tenant #1 about a block up the street and talked Tenant #1 into coming back to the Program. Staff #1 said Tenant #1 was walking in the middle of the street with Tenant #1's walker and there was no traffic in the street. Tenant #1 told her Tenant #1 was upset about an incident with Tenant #2 that morning during a church service. Tenant #1 said Tenant #2 had told Tenant #1 to get away when Tenant #1 tried to pull up a chair and sit by Tenant #2. Tenant #1 said Tenant #1 wanted to go to a family member's house. Tenant #1 was crying when Staff #1 reached Tenant #1. Staff #1 said more than three months ago Tenant #1 went out the back door, the buzzer sounded and staff responded. Tenant #1 had fought with Tenant #2 that day too and was going to a family member's house. Staff #1 said Tenant #2 could be argumentative in the past couple of months. Staff #1 said the door chimes were audible if not vacuuming or giving a shower. Staff #1 said there was enough staff to meet the needs of the tenants. Staff #1 said Tenant #1 did not have any injuries and was wearing pants, a tee shirt blouse, a sweater and shoes at the time of elopement.

Staff #2 had a written statement and was interviewed regarding the incident with Tenant #1. She had left on 11-4-12 at 3:00 p.m. after shift report was finished. Tenant #1 was sitting with staff. Tenant #1 was inside the building and present when she left for the day. Staff #2 said there was enough staff to meet the needs of the tenants. Staff #2 said the door chimes were audible.

Staff #3 had a written statement. On 11-4-12 Staff #3 was visiting with Tenant #1 because Tenant #1 looked a bit upset and Tenant #1 told Staff #3 one of the other tenants was mean to Tenant #1 at breakfast. Tenant #1 could not remember who it was and seemed confused when they were talking. Staff #3 said she was going to clean a room and said she would see Tenant #1 later.

Tenant #1 responded and said "see you another day." Staff #3 went to help Staff #4 clean and told Staff #4 about what Tenant #1 and Staff #3 talked about. They both thought it was odd Tenant #1 said "see you another day" and then they heard the door buzzer and went to check on Tenant #1. Staff #1 was already down the block walking Tenant #1 back home.

Staff #4 had a written statement. She arrived at work on 11-4-12 and got report. Staff #3 and Staff #4 went to clean an apartment. Staff #3 told Staff #4 that Tenant #1 was upset with Tenant #2. Then Tenant #1 told Staff #3 Tenant #1 would see Staff #3 later, as if Tenant #1 was going somewhere. Tenant #1 left the Program while the vacuum was running, apparently. Staff #4 heard the door and went to check where Tenant #1 was and saw Staff #1 guiding Tenant #1 back.

The Nurse Consultant had a written statement and was interviewed. She talked with Tenant #3 and Tenant #3 was watching television and saw Tenant #1 go out the door. The doorbell sounded, Tenant #3 saw Tenant #1 look both ways when Tenant #1 was crossing the street. Tenant #3 went to get staff, staff went right out and Tenant #1 was brought back. The Nurse Consultant stated Tenant #1 had not attempted any previous elopements and did not have any subsequent attempts after the elopement. The Nurse Consultant felt Tenant #1 was safe at the Program due to many staff and two hour safety checks.

The Program was not a dementia specific program and was not required to have door alarms. The exit doors had an audible door chime that went off when the doors were opened. The monitors tested the north and south exit doors and the door chimes were audible at each end of the building.

According to the State Climatologist, on 11-4-12 at 2:52 p.m. at the Davenport Airport the temperature was 47 degrees, winds were light and variable and there was no precipitation.

The possible terrain Tenant #1 traveled during the elopement included concrete sidewalks, a city street, a concrete parking lot and grass. The approximate distance Tenant #1 might have traveled was .10 of a mile or less.

The Program's Missing Tenant Policy indicated the Program was to ensure prompt and appropriate response by staff and emergency personnel in an effort to maintain tenant safety. The Program's policy was followed.

The Program reported the elopement to the Department and an incident report was completed.

Tenant #1 reported to staff Tenant #1 was upset about an incident that occurred between Tenant #1 and Tenant #2. Tenant #1 eloped from the Program and was going to a family member's house. The service plans did not reflect the behaviors between Tenant #1 and Tenant #2. While a deviation from requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.