IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 41842-C
41843-I

December 26, 2012

Ms. Cheri Orcutt, Director
Meadows Assisted Living
200 McCarren Drive
Manchester, IA 52057

RE: Final Complaint/Incident Investigation Report – Meadows Assisted Living, Manchester, IA

Dear Ms. Orcutt:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 7 & 10, 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:

Cheri Orcutt, Director
The Meadows Assisted Living
200 McCarren Drive
Manchester, IA 52057

Complaint/Incident Intake #: 41842-C
41843-I

Date of Complaint/Incident Investigation:

December 7 & 10, 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:	38
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	40
TOTAL census of Assisted Living Program	40

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Other

Complaint/Incident Allegation #41843-I: The Program reported a tenant eloped.

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4). Tenant #2 eloped on 12-3-12.

  Tenant #2, an 89 year old, was admitted on 1-2-11 and diagnoses included: Alzheimer's Disease, Depression, Diverticulitis, Hyperlipidemia and Osteoarthritis. Tenant #2 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. On 12-8-12 Tenant #2's family removed Tenant #2's belongings from the apartment and discharged Tenant #2 from the Program.

  According to notes dated 9-10-12, staff reported last evening that Tenant #2's family brought Tenant #2 back and reported Tenant #2 was taken to an urgent care clinic and had a bottle of Cephalexin. A call was placed to a nurse at the urgent care clinic and it was explained Tenant #2 had some sores under Tenant #2's breasts. Cephalexin 500 mg twice daily for seven days was ordered for fungal infection. Loprox 0.77% gel under both breasts twice daily for 15 days was ordered. According to notes dated 9-11-12, Tenant #2's family decided to go with Clotrimazole cream versus Loprox. A doctor's order was received to apply twice daily for 10 days. The cream was added to the Treatment Administration Record and staff was delegated regarding the treatment. Evaluations were completed as needed and the service plan was updated and reflected the treatment. According to the notes, a 90 day evaluation was completed on 9-21-12 and the skin was clear and there were no current lesions or open areas noted.

According to notes dated 11-29-12, Tenant #2's apartment had a foul odor that had a yeasty smell. Tenant #2 had a history of acute dermatitis under breasts in the past. The Nurse assessed skin under the breasts and skin was bright red in color with fluid filled lesions present. An order was obtained for Clotrimazole cream twice daily to affected areas. The service plan was adjusted. Nurse delegations were completed related to the treatment. The service plan reflected staff provided bathing reminders for Tenant #2 three times per week, staff would turn on the water and Tenant #2 showered independently. A Service Plan Sign Off document indicated staff provided the services as listed in the service plan. The Service Plan Sign Off document indicated staff on day, evening and night shifts consistently signed that services were provided as listed in the service plan for October, November and December until Tenant #2 was discharged.

According to an Incident Report dated 12-3-12 at 1:20 p.m., staff went to Tenant #2's apartment to notify Tenant #2 of a hair appointment at 1:45 p.m. and to assess an area under breasts. Tenant #2 was not in Tenant #2's apartment. A search of tenant apartments was completed and Tenant #2's family was called. At approximately 1:40 p.m. Tenant #2 walked in the front door and Tenant #2 was unable to tell staff where Tenant #2 had been. Tenant #2 was unclear of what had occurred and Tenant #2 stated Tenant #2 was out for a walk down the street and was out and about, possibly south and west. Tenant #2 also shared Tenant #2 might have been in a car. It was thought Tenant #2 might have been recalling an appointment with a hair dresser. Tenant #2's family was called and safety checks were put into place.

The Nurse was interviewed and had documentation in notes regarding the incident with Tenant #2. At 1:20 p.m. the Nurse went to assess irritation under Tenant #2's breasts and to let Tenant #2 know the hair dresser would be coming to pick Tenant #2 up. Tenant #2 was not in Tenant #2's apartment and had not signed out. The Nurse walked around the inside of the building, looking out all doors leading outside and did not see Tenant #2. All staff and the Director were notified. The hair dresser was called to see if Tenant #2 had already been picked up. A door to door search of all apartments was completed and Tenant #2's family was called. Just after the apartment search was completed, Tenant #2 walked in the front door. Tenant #2 was asked where Tenant #2 had been and Tenant #2 was unsure. The notes indicated it was out of the normal routine for Tenant #2, as Tenant #2 did typically walk around the building shortly after lunch but normally wore a jacket and was back by approximately 1:00 p.m. On that day Tenant #2 did not have a jacket, at 1:20 p.m. Tenant #2 was not found and Tenant #2 was unable to tell staff where Tenant #2 had been. Several staff walked around the building and did not see Tenant #2 on Program property. Tenant #2 did not have any exit seeking attempts or elopements prior to the incident. Tenant #2 was placed on safety checks and the checks were added to the service plan. The Nurse said Tenant #2 did not have injuries related to the incident. Tenant #2 was wearing long pants, shirt and shoes. Tenant #2 did not have a jacket. The Nurse said Tenant #2 normally went for walks but never left the grounds.

The Director said she was notified by the Nurse that Tenant #2 was missing. Staff checked apartments and checked outside. Tenant #2's family was contacted. Staff checked the perimeter of the building and Tenant #2 was not found during the checks. The Director said staff followed the policy regarding a missing tenant. Tenant #2 walked in the front door at 1:40 p.m. wearing a shirt, pants and shoes.

Tenant #2 did not have a coat on at the time of the incident and the Director had commented they always saw Tenant #2 with a coat. Tenant #2 did not have any injuries. Tenant #2 said Tenant #2 had just been down the street and had not been to the nearby nursing facility. The Director said previously Tenant #2's routine could be predicted and there were never any concerns with routine until that day. The Director said Tenant #2 did not have a history of elopements.

Staff #1 said Tenant #2 ate lunch on Monday 12-3-12 and right before 1:30 p.m. the Nurse realized Tenant #2 was not in Tenant #2's apartment. Staff checked all apartments and checked outside. Staff #1 went outside to a nearby nursing facility to pick up another tenant and did not see Tenant #2 on her way to the nursing facility or on the way back to the Program. Staff #1 said Tenant #2 walked in the front door and did not have a jacket which was unusual for Tenant #2. Tenant #2 said Tenant #2 was down the lane. Tenant #2 was wearing a shirt, pants and shoes.

Staff #2 saw Tenant #2 at lunch on 12-3-12. Staff #2 saw Tenant #2 get up from the table and was headed through the commons toward Tenant #2's apartment. Staff #2 did not see Tenant #2 outside and was the first person to meet Tenant #2 at the door. Tenant #2 said Tenant #2 had gone for a walk down the street to get fresh air. Tenant #2 looked normal when Tenant #2 returned and was wearing pants, a shirt and did not have a coat. Tenant #2 often took a walk after lunch, according to Staff #2. Staff #2 participated in the search for Tenant #2.

Staff #3 saw Tenant #2 at lunch on 12-3-12. Tenant #2 routinely went for a walk at lunch and was typically back by 1:00 p.m., at the latest 1:05 p.m. or 1:10 p.m. Staff #3 participated in the search for Tenant #2.

Staff #4 saw Tenant #2 when Tenant #2 returned. Staff #4 said it was normal for Tenant #2 to go for walks around lunch time. Staff #4 participated in the search for Tenant #2 and searched the exterior of the building and checked the solarium and courtyard.

Staff #5 saw Tenant #2 at lunch on 12-3-12 but did not see Tenant #2 get up from lunch. Staff #5 participated in the search for Tenant #2.

Evaluations were completed and the service plan was updated after the incident on 12-3-12. The service plan reflected safety checks and Tenant #2 needed a chaperone on walks outside.

According to Meal Attendance Sheets, Tenant #2 ate lunch on 12-3-12. Safety checks were implemented after the incident and were consistently documented as completed. The Program was not a dementia specific program and was not required to have operating door alarms. Tenant #2 was not able to report Tenant #2's whereabouts and it was not witnessed, therefore the possible terrain Tenant #2 traveled during the incident could not be determined.

The Director and the Nurse agreed at 9:30 p.m. on 12-3-12 that in addition to the hourly checks at night, they wanted to have Tenant #2's door locked in the night as another safety measure. The apartment door was locked at night only from Monday 12-3-12 to Thursday 12-6-12.

Tenant #2 was made aware of that on 12-4-12 and was agreeable. Tenant #2 could come and go freely and could easily open the apartment door per usual. The door lock only prevented anyone from entering without Tenant #2 being made aware. The monitor tested a door lock in a tenant apartment and with the door locked the monitor was able to open the door and exit the apartment. The locked door did not prevent the monitor from exiting the apartment.

According to the State Climatologist on 12-3-12 at 1:15 p.m. at the Independence Airport, the temperature was 64 degrees, there were cloudy skies, no precipitation and the winds were from the southwest at 22 miles per hour (mph) with gusts to 28 mph.

It appeared the Program followed the Missing Tenant Search policy. An Incident Report was completed and the elopement was reported to the Department.

Per review of incident reports, tenant files, staff interviews, monitor observations and review of Program documents there were no concerns identified related to the elopement reported.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation #41842-C: It was alleged there were concerns with tenant rights regarding the discharge process.

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4). Tenant #1 and Tenant #2 were identified by the Program as current tenants on 12-7-12; however, both were considered voluntary transfers. Tenant #3 was voluntarily discharged from the Program on 7-13-12 to a higher level of care.

  Tenant #1, an 87 year old, was admitted on 2-28-09 and diagnoses included: Hypertension (HTN), Dementia and Osteoporosis, Anemia, Hearing Loss and Osteoarthritis. Tenant #1 was staged at a four on the GDS, which indicated moderate cognitive decline. According to Program document, discussions had been carried out with family regarding Tenant #1's increasing needs. Family understood and said they were looking for direction. Family was made aware Tenant #1 was capable of being at the Program but it would be in their best interest to make an application to a nearby facility for placement if that was where they wished for Tenant #1 to go. The family was made aware if there were concerns about wandering or Tenant #1 needed more safety checks family would likely need to provide additional care until alternate placement was made. Family was very kind and willing to participate where and when needed. Tenant #1 was considered a voluntary transfer.

  Tenant #2's file was reviewed. According to an Incident Report dated 12-3-12 at 1:20 p.m., staff went to Tenant #2's apartment to notify Tenant #2 of a hair appointment at 1:45 p.m. and to assess an area under breasts. Tenant #2 was not in Tenant #2's apartment. A search of tenant apartments was completed and Tenant #2's family was called at approximately 1:40 p.m.

Tenant #2 walked in the front door and Tenant #2 was unable to tell staff where Tenant #2 had been. Tenant #2 was unclear of what had occurred and Tenant #2 stated Tenant #2 was out for a walk down the street and was out and about, possibly south and west. Tenant #2 also shared that Tenant #2 might have been in a car. It was thought Tenant #2 might have been recalling an appointment with a hair dresser. Tenant #2's family member was called and safety checks were put into place.

The Director stated they were not able to keep Tenant #2 safe and could not keep up the safety checks. According to a Program record, conversation began with family regarding the need for additional services beyond what the Program could provide. Family was agreeable and planned to look for alternate placement. Tenant #2's cognitive status combined with the elopement on 12-3-12 was the reason for the process to begin. The Program did not feel Tenant #2 was an exit seeker but were not able to account for her whereabouts for approximately 20 minutes. There was a change in Tenant #2's behavior and was there was a concern Tenant #2 would not be able to make appropriate decisions if necessary. According to a Program record, on 12-3-12 the Director discussed concerns regarding Tenant #2 with the family and recommended they seek alternative placement. Family asked if there was a timeline and was told the Program would not be able to keep up the safety checks long term but could commit to three days. On 12-6-12 the Director called family and asked if alternate placement was found or if there was an alternate plan. Family was reminded of the conversation on 12-3-12 and was told the Program was able to do the additional checks only for three days but if there were further concerns family would need to come and stay with Tenant #2 around the clock. Tenant #2 was found in Tenant #4's apartment on 12-6-12 visiting and reading the newspaper. The Director said it was concerning because it was not normal behavior for Tenant #2. The Director told a family member the Program did not have adequate staffing to do 15 minute checks or 1 hour checks for an extended period of time. Choices discussed included to provide someone to stay with Tenant #2 or find alternative placement. Home health agencies, the nursing facility, family members and church members were suggested. The Director also checked to see if any staff members would provide assistance off their regular schedule. The Nurse called staff to see if any were willing to provide one on one care for the family and had potential candidates. On 12-6-12 at 3:30 p.m. family called back and said they were considering a locked facility, they were able to get a respite room and Tenant #2 would stay there until Tenant #2's room was ready.

According to a Program record, on 12-6-12, family was upset regarding Tenant #2's door being locked. The Director and the Nurse agreed at 9:30 p.m. on 12-3-12 that in addition to the hourly checks at night, they wanted to have Tenant #2's door locked in the night as another safety measure. The apartment door was locked at night only from Monday 12-3-12 to Thursday 12-6-12. Tenant #2 was made aware of that on 12-4-12 and was agreeable. Tenant #2 could come and go freely and could easily open the apartment door per usual. The door lock only prevented anyone from entering without Tenant #2 being made aware.

The doctor was apprised of the concerns regarding Tenant #2's safety. The doctor did not have any further suggestions to offer regarding steps they could take to care for Tenant #2. The doctor did recommend calling the office at 8:00 a.m. to schedule an appointment to see if anything else was going on.

Family was made aware the doctor wanted to see Tenant #2 the next day. Tenant #2's family moved belongings out on 12-8-12 and discharged Tenant #2 from the Program. The Director said no official notice was given and no immediate notice of discharge was given. Tenant #2 was not required to move out in three days; however the Program could not keep providing the safety checks. The Director said Tenant #2 was a danger to self. Tenant #2 was considered a voluntary transfer.

Tenant #3, a 92 year old, was admitted on 9-17-05 and diagnoses included: Chronic Obstructive Pulmonary Disease, Depression, Gastro Esophageal Reflux Disease, Gout, HTN and Hyperlipidemia. Tenant #3 was listed as a voluntary discharge on 7-13-12 to a higher level of care. The Director said Tenant #3 had falls and family provided additional services until Tenant #3 was discharged. No official notice was given and the concern with Tenant #3 was a danger to self regarding falls and assistance with transfers. Tenant #3 was a voluntary transfer.

The Director said tenant rights were upheld with Tenants #1, #2 and #3. The Director said the Occupancy Agreement was followed for Tenants #1, #2 and #3. The Program provided a list of discharged tenants in the past six months and all discharges were voluntary.

The Occupancy Agreement disclosed the Admission and Discharge-Limits of Service, which included a tenant who is dangerous to self or others or staff. The Occupancy Agreement also indicated under Services, if a tenant's level of care exceeded the staffing capabilities, family would be asked to assist with tenant cares while other arrangements were made. Tenants #1, #2 and #3 had signed occupancy agreements. The Program appeared to follow the Counseling for Termination of Residency policy.

Three tenant families were interviewed. The majority of family interviews did not identify any concerns with tenant rights. One family member said the tenant wanted to return to the Program and it was not an easy transition. The family member said the Director was very good and provided support because the situation was stressful for everyone. The family member had no complaints with services and said tenant rights were upheld. Another family member said it was hard to find another choice for placement; however, the Director had been really good and tenant rights were upheld. The family member had no qualms about cares or services provided.

Per review of tenant files, family interviews, staff interviews and review of the Occupancy Agreement no concerns regarding tenant rights during the transfer process were identified.

- Regulatory Insufficiency: None noted.