IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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Complaint/Incident Intake #: 41709-I

January 15, 2013

Ms. Shelley Meyer, Administrator
Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

RE: Final Complaint/Incident Investigation Report – Shores at Pleasant Hill, Pleasant Hill, IA

Dear Ms. Meyer:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 3, 2013, 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:

Shelley Meyer, Administrator
The Shores at Pleasant Hill
1500 Edgewater Drive
Pleasant Hill, IA 50327

Complaint/Incident Intake #: 41709-I

Date of Complaint/Incident Investigation:

January 3, 2013

Monitor(s):

Lori Miner, RN BSN

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:	46
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	47
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	65

Program History – The program received a regulatory insufficiency in the area of Structural during the April 4, 2012 recertification on-site.

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

A. Staffing

Complaint/Incident Allegation: The program reported Tenant #1 eloped from the program on 11-22-12.

- Monitoring Observation: On 11-22-12, family members for a tenant residing in one of the secure memory care units left the secured second-floor unit (not Tenant #1's family). The family members were not aware Tenant #1 was a tenant at the program. The program reported most, if not all family members, had the code necessary to enter or exit the unit. When the family members left the unit, Tenant #1 left with them through the alarmed door and got on the elevator. Because the code had been entered, the alarm did not sound. Tenant #1 went from the second to first floor, exited the main door, used the sidewalk to get to the entrance of the first floor memory care unit, and was assisted back into the building by a staff member. The program documented the exit from the building and the entrance back into the building on security video. Tenant #1 exited the building at approximately 3:13 p.m. and re-entered at 3:15 p.m. Tenant #1 was dressed in blue jeans, sweatshirt, and slippers at the time of the elopement. The outside temperature was in the 60's and the skies were fair with a breeze present. A program nurse assessed Tenant #1 and found no injuries following the elopement. 30-minute checks were started and continued for 24 hours, when hourly checks were resumed. The program completed an internal investigation and an incident report was completed. The program reported the incident to the department appropriately.

Staff #1, Care Attendant, reported Tenant #1 liked to walk a lot, and counted doors and windows. Tenant #1 checked to see that doors were locked and walked on. Tenant #1 was on hourly checks at the time of the elopement. Staff #1 was surprised to learn that Tenant #1 had gotten out of the building, as Tenant #1 was not exit-seeking. Tenant #1 was described as easily redirected.

Staff #2, Care Attendant, reported Tenant #1 wandered the halls and checked for locked doors, but did not describe Tenant #1 as exit-seeking. Staff #2 stated Tenant #1 was checked hourly prior to the elopement and was easily redirected.

Tenant #1, 72 years old at the time of the incident, was admitted on 1-18-12 and had a diagnosis of Dementia. Tenant #1 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline.

The program nurse was interviewed and stated Tenant #1 was not exit-seeking prior to the elopement. The nurse confirmed Tenant #1 liked to count windows and doors and would set off alarms by opening doors. Staff responded immediately to find Tenant #1 had moved to the next door to check it. Tenant #1 had not talked about leaving.

The service plan dated 9-18-12 was in effect at the time of the elopement. The service plan identified Tenant #1 as walking in the hallway, always walking the same route, counting doors and windows. The service plan identified specific interventions to redirect Tenant #1 if Tenant #1 walked into another tenant's apartment.

Following the elopement of 11-22-12, evaluations and service plan were completed on 11-23-12. The service plan was updated to include closer observation when visitors were in the secured unit, and escorting visitors to the elevator to ensure Tenant #1 did not accompany the visitors.

The administrator stated additional signs were posted reminding visitors not to assist anyone out of the building. Letters were also sent to family and friends of tenants residing in the secured unit to observe for tenants who may want to leave with them.

Tenant #1 had not previously exhibited exit-seeking behavior, and has not tried to exit the building since the incident of 11-22-12. The program updated the service plan and alerted visitors to tenants who may try to leave.

- Regulatory Insufficiency: None noted.