IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 42080-I

February 12, 2013

Ms. Nicole Ellermeier, Executive Director
Whispering Creek
2607 Nicklaus Blvd.
Sioux City, IA 51106

RE: Final Complaint/Incident Investigation Report – Whispering Creek, Sioux City, IA

Dear Ms. Ellermeier:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 28, 29, 30 & February 4, 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 515/281-4116 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 #:** 42080-I

Nicole Ellermeier, Executive Director
Whispering Creek
2607 Nicklaus Blvd
Sioux City, IA 51106

Date of Complaint/Incident Investigation:

January 28, 29, 30 and February 4, 2013

Monitor(s):

Stephanie Cummins, MA
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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	15
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	20

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	14
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	34

Program History – There were regulatory insufficiencies found in the areas of Nurse Review, Evaluations and Medications during this certification period.

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

A. Staffing

Complaint/Incident Allegation: The Program reported a tenant eloped.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1 eloped from the Program on 12-25-12.

  Tenant #1, an 80 year old, was admitted on 10-29-12 and diagnoses included: Atrial Fibrillation and Aortic Stenosis. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

  According to an Incident Report dated 12-25-12 at 4:30 a.m., Tenant #1 was sitting on the couch with another tenant when staff started toileting other tenants at approximately 4:15 a.m. When staff came out of another tenant's apartment, another staff was bringing Tenant #1 into the dementia unit door. It was explained the police had called the Program's phone and said the newspaper delivery person saw Tenant #1 in the parking lot and asked if Tenant #1 lived there. Tenant #1 said Tenant #1 did not know but needed a ride to school. The newspaper delivery person and Tenant #1 were in the independent living entry way. Staff brought Tenant #1 back to the dementia unit around 4:40 a.m.

Tenant #1's vitals were taken and were within normal range. Staff checked the doors and the door next to the laundry room was not latched shut. Staff went through that door after filling the mop bucket. The door usually shut on its own. There were no visible injuries and no changes with Tenant #1 noted. Tenant #1 did not have any complaints of pain and first aid treatment was not needed. Tenant #1's doctor and family were notified. Tenant #1 was wearing a coat and hat while sitting on the couch as Tenant #1 had refused to take them off. Tenant #1 was wearing a hat and coat when Tenant #1 was found outside. Vital signs on the Incident Report were as follows: Blood Pressure 130/72, Pulse 64, Respirations 16 and Temperature 98.9.

According to the Program's Investigation Report, Tenant #1 exited the Program at approximately 4:15 a.m. on 12-25-12 and returned to the Program at 4:24 a.m. Tenant #1 left the dementia unit through a door that was not properly latched. Tenant #1 was appropriately dressed and was not harmed. Maintenance staff fixed the door to ensure it latched, all doors would be checked at shift change to ensure they were all secured, disciplinary action was completed for staff not following policies, reviewed and reeducated staff on applicable policies, a task sheet was started for 30 minute checks and interventions were added regarding exit seeking behaviors.

Staff #1 worked at the time of the elopement and was interviewed. On 12-25-12 Tenant #1 had been wandering all night and was on the couch napping. Staff #1 heard a noise and went to check on another tenant who had recently returned from the hospital and was fall risk. Tenant #1 had been sleeping on the couch and Staff #1 did not call for another staff to watch. Staff #1 assisted the other tenant and it took approximately 15 minutes. After Staff #1 finished assisting the other tenant Staff #1 did not see Tenant #1 and went to check Tenant #1's room. On the way to Tenant #1's room Staff #1 heard the dementia unit door open. Staff was bringing Tenant #1 into the dementia unit. Tenant #1 was wearing a coat, a hat and tennis shoes. Tenant #1's vital signs were checked and were within the normal range. There were no injuries to Tenant #1. The doors were checked and found the door by the laundry room had a latch that did not work. The nurse was notified and the nurse said the nurse would notify the family and the Executive Director. Prior to the elopement, Tenant #1 pushed on the exit doors; however, was always stopped with the 15 second delay. Tenant #1 was easily redirected away from the exit doors. The door Tenant #1 went out was not alarmed as it was an internal door. Tenant #1 ambulated independently and had a cane but did not use it. Tenant #1 still went to the doors but did not push on them. Tenant #1 wandered but had not tried to leave since and the service plan reflected interventions. Staff #1 said door checks were completed since the elopement and the door had always worked properly.

Staff #2, (maintenance staff) was interviewed. Staff #2 said he was notified the door in the dementia unit was not latching. He checked the door and it latched every time. To provide reassurance he added more latch pressure. He said the door functioned appropriately when tested. The door was located between the dementia unit and the kitchen hallway. The door did not lead to an exterior door. The door was not alarmed and automatically locked from the tenant side of the door. He said there had not been any issues with doors or alarms within the past three months.

The Executive Director said the she was notified of the incident around 8:00 a.m. Tenant #1 and another tenant were in central area and Staff #1 did not contact a second staff to start 4:00 a.m. toileting. Tenant #1 was found by the newspaper delivery person. The newspaper delivery person could not get in as the doors were locked and called the police. The police contacted staff. She stated approximately seven minutes elapsed between the time, the toileting task was started and Tenant #1 was returned to the Program. Tenant #1 was wearing a coat, hat and shoes. Vital signs were checked. Door checks and visual checks every 30 minutes were initiated. There was no prior history of the doors not functioning and there were no issues with alarms not working. The door automatically locked and malfunctioned as it did not latch.

Cognitive, health and functional evaluations were completed on 12-26-12 after the elopement. The service plan was also updated after the elopement and reflected interventions.

The door was inspected and worked appropriately at the time of the investigation. It could not be determined which exterior door Tenant #1 exited the Program.

After Tenant #1's elopement, half hour checks were completed on Tenant #1. Staff initialed and indicated where Tenant #1 was during the check. The checks were consistently documented as completed. Door checks at shift change were also initiated. The checks provided the date, time and arriving and departing staff signatures. Checks were not documented as completed from 12-31-12 through 1-9-13.

The ALP Entrance Form indicated on third shift there was one staff on duty in the general population and one staff on duty in the dementia unit on third shift.

The Program's Special Memory Care Unit Policy and Procedure indicated staff assigned to the unit had their walkie-talkie and portable phones with them at all times. If only one staff member was in the dementia unit and a tenant then required assistance in their apartment, the staff member must call another staff member prior to beginning cares. The second staff would then supervise the other tenants. There were no exceptions to the policy and under no circumstances would the dementia unit be left unsupervised, according to the policy.

Staff #1 signed acknowledgement of the policy dated 1-6-12 and then a re-education of the policy and signed acknowledgement on 12-26-12.

According to the State Climatologist, on 12-25-12 at 3:52 a.m. at the Sioux City Airport, the temperature was 2 degrees, wind chill was -17 degrees, there were clear skies and winds were from the North at 15 miles per hour.

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

After Tenant #1's elopement, half hour checks were completed on Tenant #1. Door checks at shift change were also initiated. Door checks were not documented as completed from 12-31-12 through 1-9-13. The Program initiated checks of the doors at shift change, which were not consistently completed.

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.