IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
43594-I

July 8, 2013

Mr. David Ayers, Administrator
Riverside Senior Living
209 Park Drive
Charles City, IA 50616

RE: Final Complaint/Incident Investigation Report, Riverside Senior Living, Charles City, Iowa

Dear Mr. Ayers:

Enclosed is the **Final Complaint/Incident Investigation Report** 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to 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:

David Ayers, Administrator
Riverside Senior Living
209 Park Drive
Charles City, IA 50616

Complaint/Incident Intake #: 43594-I

Date of Complaint/Incident Investigation:

May 28, 2013

Monitor(s):

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:	11
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	15

Program History – The program has not received any regulatory insufficiencies 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 exited the building and the alarm sounded; however, staff failed to investigate why the alarm was sounding.

- Monitoring Observation: Two tenant files were reviewed. Tenant #1 exited the building on 4-29-13.

  Tenant #1, a 90 year old, was admitted on 12-29-11 and diagnoses include: Dementia, Mixed Incontinence, History of Left Knee Replacement, History of Heart Stent and Angiogram, Hypertension and Hyperlipidemia. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. A 90 day nurse review completed on 4-17-13 included functional, cognitive and health evaluations and a service plan review. The service plan reflected Tenant #1 used a walker as needed when having back pain. Tenant #1 participated in exercises daily and had no falls. Tenant #1 was not able to use the emergency pendant so staff checked Tenant #1's whereabouts and activity every half hour during waking hours and twice during the night for safety. The service plan reflected a patio fence had been installed to reduce elopement risk. Exit door to patio was alarmed. Tenant #1 was highly involved in activities and family visited often to reduce the risk of desiring to leave.

  According to an Incident Report dated 4-29-13 at 4:38 p.m., another tenant notified Staff #1 that Tenant #1 was outside the facility near the swinging bridge. Staff #1 had toileted Tenant #1 at 4:20 p.m. and changed Tenant #1's incontinent brief. The alarm for the north tenant door came across the pager at 4:26 p.m. but Staff #1

thought it was another tenant who had been walking in the hall and frequently opened the north and south tenant doors to check the weather. Staff #1 went out to get Tenant #1 and met Tenant #1 at the bridge and walked Tenant #1 back with Staff #1, unlocked the north tenant door and re-entered the building. No sign of fall or injury was noted and Tenant #1 denied the same. Staff #1 notified the Nurse Manager and Administrator. Tenant #1 did not have any signs of injury. Vital signs were checked: Blood Pressure 112/76, Temperature 97.2, Pulse 79 and Respirations 20. Tenant #1 displayed usual behavior and activity. An Instant Alarm was applied to the north tenant door. The alarm could not be turned off without entering a code at the door. A message was left for a family member at 5:44 p.m. and the physician was notified via fax at 6:30 p.m.

According to Tenant Notes, Tenant #1 had a previous elopement on 5-10-12 without injury. A family meeting was held after the incident and a decision was made to install a fence around the patio.

Staff #1 said she went into Tenant #1's apartment for a brief check on 4-29-13 at 4:20 p.m. and changed Tenant #1's brief. Another tenant normally walked the halls and would peek out the doors. When the doors were opened a message would come through the pager indicating north tenant door. Staff #1 had seen the other tenant right before the door alarmed and figured that tenant went out the door. About 4:30 p.m. another tenant had been outside, came in and told Staff #1 that Tenant #1 was by the swinging bridge. Staff #1 was by the front desk, ran down the hall and went out the north tenant door and hollered for Tenant #1. Staff #1 stayed on the steps and asked Tenant #1 to come back and Tenant #1 did. Once in the building, Staff #1 told Tenant #1 not to go out that door. Tenant #1 returned to Tenant #1's apartment. Staff #1 called the Nurse Manager and Administrator, completed an Incident Report and a statement form.

Staff #1 stated Tenant #1 was dressed appropriately with pants, shoes, shirt and a long sleeve sweater. Staff #1 said it was a warmer day, dry and no rain. Staff #1 did not observe any injuries on Tenant #1 and Tenant #1 did not verbalize any injuries.

According to a written statement by Staff #1, at 4:20 p.m. Staff #1 went in Tenant #1's room to change Tenant #1's brief and Tenant #1 was currently in the room. Staff #1 and Tenant #1 changed the brief. When Staff #1 walked out of the room, another tenant was walking the hall that usually peeked out the north tenant door and south tenant door so when the north tenant door went off at 4:26 p.m. Staff #1 figured it was the other tenant. Then another tenant came to Staff #1 at 4:38 p.m. and told Staff #1 that Tenant #1 was down by the swinging bridge so Staff #1 ran down the hall and was out the door by 4:40 p.m. Tenant #1 was half way across the bridge. Staff #1 yelled for Tenant #1 and Tenant #1 waved and started heading back at 4:46 p.m. Staff #1 and Tenant #1 walked back into the building. When Staff #1 asked Tenant #1 what Tenant #1 was doing out there, Tenant #1 said trying to get exercise so decided to go for a walk. Staff #1 told Tenant #1 not to leave like that and if Tenant #1 wanted to go for a walk to get exercise that Tenant #1 could go for a walk in the fenced in garden area. Tenant #1 then apologized and said Tenant #1 probably already knew that and just forgot. Tenant #1 apologized again saying Tenant #1 probably caused a lot of problems.

According to the Nurse Manager, she was called by Staff #1 around 4:50 p.m. The Nurse Manager had just left and returned to the program about 5:30 p.m. Tenant #1 and Tenant #1's spouse were sitting on a couch and had just finished eating. The Nurse Manager did a head to toe assessment on Tenant #1 in Tenant #1's apartment. Tenant #1 was confused by the whole thing. Tenant #1 didn't know why Tenant #1 couldn't go for a walk as it was a beautiful day. The Nurse Manager wrote up the Incident Report, faxed the physician and called a family member. The Administrator was there and he contacted the maintenance staff who hooked up an Instant Alarm. The Nurse Manager left around 7:00 p.m. The next day she completed the self-report to the Department.

According to the Administrator, Staff #1 called him at 4:50 p.m. and he arrived at the building. Staff #1 said Tenant #1 went out the north tenant door. Staff #1 called at Tenant #1 and Tenant #1 returned. A day or two prior to the incident Tenant #1's family member took Tenant #1 out that door and took Tenant #1 for a walk. Prior to that, Tenant #1 did not show any interest regarding the north tenant door. A maintenance staff member came in and put an alarm on the door. The Administrator came back later to make sure the alarm was installed and operating.

Thirty Minute Documentation Logs were reviewed for Tenant #1 from 4-21-13 through 5-2-13. The logs reflected consistency in checking Tenant #1 every 30 minutes indicating location of Tenant #1 and initials of staff member completing the check. On 4-29-13, Staff #1 indicated Tenant #1 was in Tenant #1's room at 4:00 p.m. and at 4:30 p.m. At 5:00 p.m. Staff #1 indicated Tenant #1 was at supper.

According to an Alarm Event Report for 4-29-13, the north tenant door alarmed at 4:26:19 p.m. and was cleared at 4:26:25 p.m. with a response time of 6 seconds. The north tenant door alarmed again at 4:40:20 p.m. and was cleared at 4:40:26 p.m. with a response time of 6 seconds. The north tenant door alarmed at 4:41:16 p.m. and cleared at 4:41:26 p.m. with a response time of 10 seconds.

The service plan was updated on 4-29-13 to reflect Instant Alarm was applied to north tenant door close to apartment. A notation on 4-30-13 indicated alarm on apartment door so staff was aware when Tenant #1 was outside of the apartment.

According to the Tenant Notes dated 5-10-13, Tenant #1 had no wandering or exit seeking behavior since the episode on 4-29-13. Tenant #1 sat on fenced-in patio very contentedly on nice days that week. Tenant #1 was highly involved in Program activities much of the day. Tenant Notes dated 5-15-13 at 10:00 a.m. (late entry for 5-14-13 afternoon) indicated the alarm was sounding and staff responded towards the alarm and reached the north tenant door. Tenant #1 and Tenant #1's spouse were trying to exit, though stopped and attempted to turn off alarm unsuccessfully. Tenant assistant reset the alarm and redirected Tenant #1 and Tenant #1's spouse towards the outdoor gated area. Tenant #1 declined and stated they would just return to their room.

The Staffing Policy indicated the Program will staff the facility 24 hours a day 7 days a week. Sufficiently trained staff shall be available at all times to fully meet tenants' needs.

The Missing or Eloped Tenant Policy indicated the Program had building safety features to reduce the risk of elopement. The facility utilized a wireless door monitoring system on all unit doors with outside exits and all exits to the building. When one of these doors was opened, the system gave an alert through the pager that was carried by staff. The door alarm system worked appropriately.

According to the Administrator, the Nurse Manager, Staff #1 and Staff #2, there was enough staff to meet the needs of the tenants.

A layout of the Program was obtained. Tenant #1's apartment was located near the exit door that sounded. The monitor observed the area. Outside the door was an approximate five foot long slab of concrete leading to six steps that went down to a sidewalk. The sidewalk led to parking spaces outside the building and around the building leading to the front door of the AL Program. It could not be determined the exact path Tenant #1 took as it was not witnessed; however, the possible path included walking out the door, down the steps, onto the sidewalk and across the street to a sidewalk that led to a swinging foot bridge. It was approximately 120 feet to the beginning of the bridge from the bottom of the steps. According to Staff #1, Tenant #1 was in the middle of the bridge when seen by Staff #1. Tenant #1 was within hearing distance when Staff #1 called to Tenant #1.

According to the State Climatologist, on 4-29-13 at 4:35 p.m. at the Charles City airport, the temperature was 70 degrees under partly cloudy skies, winds from the southeast at 14 miles per hour and no precipitation.

An incident report was completed and the Department was notified appropriately.

Per review of tenant files, interviews, review of policies and observations, Tenant #1 exited the building, the alarm functioned but staff did not respond. When staff was informed of Tenant #1 being outside, Staff #1 responded immediately. Tenant #1 was located and did not sustain any injuries. Tenant #1 was dressed appropriately and was redirected into the building. The service plan was updated and reflected various interventions to reduce exit seeking behaviors. Staff was re-trained regarding safeguarding tenants at risk of elopement.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))