IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
44399-I

July 25, 2013

Ms. Dawn Beard, Manager
Maples Assisted Living
98 Bolger Drive
Fayette, IA 52142

RE: Final Complaint/Incident Investigation Report, Maples Assisted Living, Fayette, Iowa

Dear Ms. Beard:

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: **Complaint/Incident Intake #:** 44399-I

Dawn Beard, Manager
Maples Assisted Living
98 Bolger Drive
Fayette, IA 52142

Date of Complaint/Incident Investigation:

July 9, 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:	14
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	15

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. Staffing

Complaint/Incident Allegation: The Program reported a tenant had eloped. The Program did not know the tenant had left until a neighbor called and notified them.

- Monitoring Observation: Two tenant files were reviewed.

  Tenant #1, an 86 year old, was admitted on 5-5-12 and diagnoses included: Dementia, Hypertension, Gouty Arthropathy and Hyperlipidemia. On 7-2-13 Tenant #1 was staged at a four on the Global Deterioration Scale which indicated moderate cognitive decline. A service plan dated 4-2-13, indicated staff monitored Tenant #1's whereabouts when Tenant #1's spouse was gone, due to Tenant #1's decreased cognitive status. If Tenant #1 went outside, staff redirected back into the Program or staff went outside with Tenant #1. During times Tenant #1's spouse was gone, staff provided extra activities with Tenant #1 or sat with Tenant #1 when anxious. If increased anxiety or agitation, staff assisted Tenant #1 to the nursing home for additional activity chores. The service plan was updated on 4-26-13 to reflect an egress exit code alarm system was installed on exit doors. Tenant #1 wore a transmitter on left ankle which would set off alarms if Tenant #1 went out. Staff would respond to the alarm and reset the panel. Universal workers checked transmitter daily for placement and function with a tester provided by the company. The service plan was updated on 7-2-13 and reflected the Program would provide one on one care with activity aide from the nursing home when Tenant #1 was restless and the spouse was gone. Staff checked all exit door alarms daily for function by using extra transmitter to set off alarms and chart all alarms working. It the alarms did not work the manager/administration would be notified immediately.

According to an Elopement Form, on 7-1-13 at 4:00 P.M., Tenant #1 was found three blocks from the Program by the school yard by the Administrator. The Program was alerted to the exit when a neighbor called the Program at 4:00 P.M. It was unknown how Tenant #1 left the Program as no alarm sounded from any exit door. Tenant #1 was found walking on the sidewalk by the school. Tenant #1 stated Tenant #1 was looking for someone Tenant #1 knew but hadn't seen anyone yet. Tenant #1 was wearing jeans, a short sleeve shirt and sneakers. The outside temperature was 79 degrees and it was sunny. Tenant #1 was returned in the Administrator's vehicle and did not have any injuries. Tenant #1 had last been seen in Tenant #1's apartment at approximately 2:50 P.M. by Staff #2.

According to Notes dated 7-1-13 at 4:20 P.M., the Administrator notified the Manager that at 4:00 P.M. the Administrator received a phone call from a neighbor stating Tenant #1 was walking by the school. The Administrator left and picked up Tenant #1 three blocks from the Program. According to Notes dated 7-1-13 at 4:30 P.M., a nurse assessment was completed. Skin was warm and dry, normal color pink. No shortness of breath and Tenant #1 denied any pain. No injuries were noted, range of motion was within normal limits and Tenant #1 was alert to self and surroundings, not alert to time or day but knew supper was soon. Tenant #1 asked if spouse was home yet. The code alert alarm transmitter remained on Tenant #1's left ankle, was tested and showed it functioned; however, the alarm did not sound when Tenant #1 left. It was unknown which door Tenant #1 exited. All door alarms were checked by the Manager with a different transmitter. Tenant #1's transmitter was replaced with a new one. Doors were tested with transmitter that was removed and all doors alarmed. It was uncertain what door Tenant #1 exited from and why the alarm did not go off. At 5:00 P.M. Tenant #1 headed outside wanting to walk. An activity aide went outside with Tenant #1. When going through the south door the alarm sounded but when Tenant #1 returned through the front door the alarm did not sound. The Manager checked all alarms again and all sounded.

Staff #2 stated she had just finished an activity and at approximately 2:50 P.M. was taking a television set to the storage room. On the way she saw Tenant #1 in Tenant #1's apartment reading the paper with the apartment door open. She then went to the Manager's office to complete paperwork and did not see Tenant #1 until the Administrator brought Tenant #1 back. Staff #2 stated no alarm sounded and no message appeared on the pager when Tenant #1 left the Program. Staff #2 stated Tenant #1 had not made any elopement attempts since the incident.

Staff #3 stated on 7-1-13 between 9:30 A.M. and 9:45 A.M. she checked Tenant #1's alarm on leg with the white transmitter box and the alarm worked. She also checked four exit doors and all worked. She stated the alarms always worked each time she checked Tenant #1.

The Manager stated she was working in the nursing home on 7-1-13 at 4:20 P.M. when the Administrator told her she had received a call that Tenant #1 was by the school and she went to get Tenant #1 and brought Tenant #1 back. The Manager went to the Program and took vitals on Tenant #1 and completed the Elopement Form. She stated it was a sunny day in the 70's. She assessed Tenant #1 who did not have any injuries. She checked all doors with the transmitter and they all sounded like they should. The system sent a message to pagers that were worn by staff. She

used the tester and Tenant #1's alarm functioned properly. She replaced Tenant #1's transmitter. Tenant #1 wanted to go back outside for a walk. He went out the south door with an activity director and the alarm went off. After Tenant #1 walked for 15-20 minutes, Tenant #1 knew it was time for supper so wanted to return to the Program. When Tenant #1 entered through the front door, the alarm did not sound. The rest of the night Tenant #1 stayed in Tenant #1's apartment. The Manager stated there had been no further elopement attempts.

The Manager stated the alarm company was coming to check the system. When it was put in place, she was told it was only required to check the transmitter. Since 7-1-13, staff also checked the doors every morning. A copy of the Exit Door Alarm Daily Functional Checks form was provided and reflected completion of daily checks from 7-1-13 through 7-8-13.

The Administrator stated the neighbor who lived in the house next door to the Program called and asked if Tenant #1 was supposed to be outside. The neighbor stated Tenant #1 was by the school on Clark Street and then turned onto Volga Street. Tenant #1 stated Tenant #1 was looking for friends and she offered Tenant #1 a ride. Tenant #1 provided two different directions on how to return to the Program and instructed her on where to park. The Administrator walked into the Program with Tenant #1 and the alarm sounded. All doors were tested and all worked. The Administrator stated Tenant #1 wore heavy denim jeans and she wondered if that was why the alarm system did not work. She stated the alarm company was coming back to re-test the system. The Administrator stated there had been no further elopement attempts.

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

According to a Staffing Policy, sufficient trained staff would be available 24 hours 7 days a week to fully meet tenants' identified needs. The policy stated the Program ensured staff providing services to tenants was trained to provide services in a safe and secure manner.

According to a Delayed Egress Exit Code Alarm System policy, the purpose was to provide safely for tenant risk of wandering due to cognitive issues as evaluated by staff. Tenants that had been evaluated and deemed at risk of wandering would have a code alert security guard bracelet placed, with family agreement, to trigger exit door alarms that sounded to alert staff.

A layout of the Program was obtained that reflected four exit doors. A map of the location where Tenant #1 was found was also provided. Tenant #1 walked a total of three blocks.

According to a website that provides historical weather data, in Oelwein, IA on 7-1-13 at 3:55 P.M. it was 78.8 degrees, 36% humidity, winds from the east northeast at 13.8 miles per hour and clear skies.

An incident report was completed and the Department was notified.

Review of Tenant #1's file, staff interviews, interviews with the Manager and Administrator, review of elopement forms and review of policies indicated Tenant #1 left the Program without staff knowledge. Tenant #1 wore an alarm transmitter that did not sound the alarm. The Program did not meet Tenant #1's identified needs.

- 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))