IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
44472-I

August 26, 2013

Ms. Jody Thomas, RN Manager
Melrose Meadows Retirement Community
350 Dublin Drive
Iowa City, IA 52246

RE: Final Complaint/Incident Investigation Report, Melrose Meadows Retirement Community, Iowa City, Iowa

Dear Ms. Thomas:

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 Insufficiencies, 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 #:** 44472-I

Jody Thomas, RN/Manager
Melrose Meadows Retirement Community
350 Dublin Drive
Iowa City, IA 52246

Date of Complaint/Incident Investigation:

July 24, 2013

Monitor(s):

Stephanie Cummins, MA

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:	21
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

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. Other

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

Monitoring Observation: Three tenant files (Tenants #1, #2 and #3) were reviewed.

Incident/Accident Reports for the past three months were reviewed and there was one documented elopement, which was regarding Tenant #1 on 7-8-13.

Tenant #1, an 89 year old, was admitted on 1-29-10 and diagnoses included: Chronic Sinusitis, Chronic Obstructive Pulmonary Disease, Hyperlipidemia and Lower Back Pain. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The service plan was updated on 6-13-13 and indicated room checks were increased to every two hours to ensure Tenant #1 remained in the assisted living (AL) area. Tenant #1's service plan was updated on 7-5-13 and reflected Tenant #1 was unsure where home was and had increased forgetfulness. After the elopement on 7-8-13, the service plan was updated and indicated continual monitoring, Tenant #1 would remain in sight of staff or family at all times when out of apartment to ensure safety and bells would be placed on the door.

According to an Incident/Accident Report dated 7-8-13, Tenant #1 eloped from the Program sometime between 5:45 p.m. and 6:30 p.m. Tenant #1 was found by police two miles from the Program. Tenant #1 was transported to a hospital by an ambulance service at approximately 7:30 p.m. Tenant #1 was brought back to the Program at 8:45 p.m. by family. Tenant #1 did not sustain any injuries and Tenant #1 said Tenant #1 was going to Indiana. Tenant #1's condition before the incident was noted as normal.

According to a Missing Tenant Report, Tenant #1 was found by police approximately one to two miles from the Program. They thought Tenant #1 was dehydrated so they transported Tenant #1 via an ambulance service to a hospital. Tenant #1 was given fluids. Family met Tenant #1 at the hospital and returned Tenant #1 to the Program at approximately 8:45 p.m. Tenant #1 had no memory of leaving the building upon return. Staff would complete two hour checks and doors would be alarmed at 6:00 p.m. until a decision was made as to the next step. Tenant #1's family was in agreement with the plan. The Missing Tenant Report indicated common areas (all floors), AL wings (all floors) and independent living (IL) wings (all floors) were checked and staff drove around building. The RN/Manager was notified at 7:10 p.m. and Tenant #1's family was notified at 7:15 p.m. The police notified the family Tenant #1 had been found at 7:30 p.m.

According to a hospital record, Tenant #1 was found wandering by police. Tenant #1 was last seen at 6:30 p.m. and then was found disappeared from the apartment. Tenant #1 was at baseline, according to family. Tenant #1 denied any pain. There were no obvious signs of injury and vitals were reviewed. Tenant #1 was asymptomatic and had no acute neurological injury. Vitals were as follows: blood pressure 158/85, pulse 88, temperature 98.1, respirations 20 and oxygen saturation 96%.

According to Nurses Notes dated 5-21-13, Tenant #1 was more confused, went outside to check Tenant #1's birdfeeders with staff assistance. Tenant #1 was redirected back inside and to Tenant #1's apartment. On 5-25-13 at 1:15 a.m. Tenant #1 walking by the IL elevators and was redirected back to Tenant #1's apartment. On 5-25-13 at 3:15 a.m. Tenant #1 walked into one of the common areas and was re-oriented and redirected back to Tenant #1's apartment. On 7-7-13 Tenant #1 was more confused and stated Tenant #1 wanted to go to New York. Tenant #1 was redirected and helped staff in the dining room. Tenant #1 was sitting in the television room most of the evening watching television. According to Nurses Notes dated 7-8-13, the RN/Manager received a telephone call from staff at 7:00 p.m. stating Tenant #1 was missing. The building was searched and family was called. Family arrived and began driving through the neighborhood. The police notified family at 7:30 p.m. that Tenant #1 was picked up approximately one mile from the Program. Tenant #1 was unharmed but transported to a hospital for observation. Tenant #1's family returned Tenant #1 to the Program at approximately 8:45 p.m. Tenant #1 was assisted to bed and given p.m. medications.

Nurses Notes after the elopement, from 7-17-13 through 7-23-13 indicated Tenant #1 was more confused, wanted to go home, walked throughout the halls, was restless and came out of the apartment at 12:30 a.m. with a winter coat on and said Tenant #1 was going to Buffalo. Nurses Notes indicated staff redirected Tenant #1 and at times had Tenant #1 call family. Review of Nurses Notes did not reveal any previous or subsequent elopements.

Staff #1 worked at the time of the incident. Staff #1 got to work at 3:00 p.m. and Tenant #1 was fine. Dinner was served at 5:00 p.m. and normally Tenant #1 walked around and went back to Tenant #1's apartment. After dinner she had showers to give and Staff #2 went into Tenant #1's apartment to give medications and Tenant #1

was not there. A search was completed inside the building and outside the building. The RN/Manager was notified and the RN/Manager notified family. The RN/Manager was notified Tenant #1 was picked up and taken to the hospital. Tenant #1 returned to the Program that night. Tenant #1 was Tenant #1's normal self and had no injuries. Staff #1 said no door alarms activated during that time; Tenant #1 would have gone out a non-alarmed door. Tenant #1 was wearing pants, shoes, a shirt, a sweater and had a coat. Tenant #1 ambulated without an assistive device or assistance. The weather was hot and sunny with no precipitation. Staff #1 said there was nothing different with Tenant #1 that day or in the days prior. Staff #1 said Tenant #1 had been fine since the elopement and was not exit seeking. There was one night when Tenant #1 said Tenant #1 was going to Buffalo but was redirected and slept the rest of the night. Staff #1 said the situation was handled appropriately and policy was followed regarding a missing tenant. Staff #1 said there had been no other elopements with any other tenants and no prior or subsequent elopements with Tenant #1. Staff #1 said there was sufficient staff to meet the needs of the tenants and none of the tenants exceeded the level of care.

The RN/Manager said she was called at about 7:10 p.m. on 7-8-13 and was told staff could not locate Tenant #1. Staff #2 did a medication pass and Tenant #1 was not there, she did a couple more, came back and Tenant #1 was not there. The RN/Manager said it was not unusual for Tenant #1 not to be in the apartment and it was about 20 minutes between attempts. Staff #2 looked through the building and Staff #2 got Staff #1 and they did a building sweep. Staff #2 got in her car and Staff #1 stayed in the building. Tenant #1's family was called. The RN/Manager came to the Program and they had not located Tenant #1. The police were not called by anyone from the Program as they wanted to make sure Tenant #1 was missing before police were contacted. A passerby called police and police located Tenant #1. An ambulance service transported Tenant #1 to a hospital and Tenant #1 returned to the Program at 8:45 p.m. There was no harm or injuries to Tenant #1. Tenant #1 was wearing pants, a shirt, shoes, socks and a light weight jacket. Tenant #1 did not ambulate with an assistive device. The RN/Manager saw Tenant #1 eating in the dining room on 7-8-13 at 5:45 p.m. The RN/Manager believed Tenant #1 went out the AL door because Tenant #1 never went out the main door and family took Tenant #1 out the AL door. Tenant #1 was unaccounted for between approximately 6:00 p.m./6:30 p.m. and was found by police at approximately 7:30 p.m. There was sufficient staff to meet the needs of the tenants and none of the tenants exceeded the level of care. The RN/Manager said the situation was handled appropriately and the policy was followed regarding a missing tenant.

According to a document dated 7-9-13 signed by the RN/Manager, since Tenant #1's return to the Program staff placed two small bells over the top of Tenant #1's door which helped to alert staff when the door was opened or closed. Staff also turned on the door alarms at 6:00 p.m. which was two to three hours earlier than the normal time. Tenant #1 was under constant supervision when out of the apartment, either with staff or family. Staff continued to redirect Tenant #1 as needed and encouraged Tenant #1 to assist them in small activities in the AL area.

The Missing Tenant Procedures indicated if it was determined a tenant was missing from the building staff would locate and/or account for the missing tenant, make the tenant safe and return the tenant. Exit doors in the AL wing were equipped with

alarms and would sound when the door was opened. Staff was to check the building first. If the building search was not successful or if a tenant was known to be outside a search of the grounds and surrounding area was conducted. If building, grounds and road search had not been successful, notify the Manager then call police within 15 minutes of notifying the Manager. In all cases when missing person procedures were instigated a Missing Tenant Report must be completed.

The Program was not dementia specific and Tenant #1 was the only tenant identified as having a GDS of four or greater. A layout of the building was provided which identified the exits and alarms. Three exits were alarmed 24 hours per day and two were alarmed at 6:00 p.m. (post elopement) and at the time of the elopement were alarmed at 8:00 p.m. The probable exit as indicated on the layout of the building was identified as one of the doors that was not alarmed 24 hours per day and at time of the elopement was alarmed at 8:00 p.m.

According to a statement provided by the RN/Manager, the Program would be installing a wandering monitoring system to the entrance doors that were not currently alarmed during the daytime hours (the front lobby, the courtyard entrance and the AL entrance). The system was to be installed on 7-23-13; however, due to an issue with the installer it would be installed on 7-29-13. In the interim staff was locking the three doors mentioned above at 6:00 p.m. rather than 8:00 p.m. as it was done previously. Staff continued to check on Tenant #1 and redirect as needed. The Program also provided the contract and bid for the wandering monitoring system.

Two exit door alarms were tested and functioned appropriately on 7-24-13. Tenant #1's apartment door was observed and there were bells on/over Tenant #1's door.

According to the State Climatologist, in Iowa City on 7-8-13 at 6:00 p.m. the temperature was 88 degrees, a heat index of 97 degrees, winds were from the southwest at seven miles per hour, there were clear skies and no precipitation.

The Program notified the Department of the elopement.

Review of Tenant #1's file, staff interviews and review of policies and documents did not identify issues with the elopement.

- Regulatory Insufficiency: None noted.

B. Nurse Review

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Three tenant files (Tenants #1, #2 and #3) were reviewed.

  Tenant #1's file was reviewed. Tenant #1's service plan was updated on 5-22-13, 6-13-13, 7-5-13 and 7-8-13. On 5-22-13 the service plan reflected Tenant #1's confusion level appeared to be increasing during the evening hours. On 6-13-13 the service plan reflected every two hour checks. On 7-5-13 the service plan indicated Tenant #1 had increased forgetfulness, was unsure of where home was and Tenant

#1's confusion level was increasing. On 7-8-13 the service plan reflected bells were placed on the door, Tenant #1 was to remain in sight of staff/family at all times when out of the apartment. Nurse reviews were not completed as needed when these changes were added to the service plan. Nurse reviews were not completed as needed.

Tenant #2, an 82 year old, was admitted on 4-5-10 and diagnoses included: Anxiety, Benign Prostate Hypertrophy (BPH), Dementia and Depression. According to a Nurses' Progress Note dated 6-30-13, Tenant #2 was diagnosed with a Urinary Tract Infection (UTI) on 5-7-13 and was started on Bactrim, which was then switched to Cipro. Tenant #2 also had a groin rash and was started on Mycolog ointment to groin rash twice daily then as needed. On 5-31-13 Tenant #2 was started on Cedfinir for an Upper Respiratory Infection (URI) and Hydrocodone 5-325 milligrams (mg) as needed for abdominal pain. Nurse reviews were not completed as needed with a diagnoses of a UTI and URI with antibiotic therapy, a groin rash with an ointment and abdominal pain. Nurse reviews were not completed as needed.

Tenant #3, an 86 year old, was admitted on 3-27-13 and diagnoses included: BPH with Obstruction, Diarrhea, Fever, Hypertension, Muscle Weakness, Peripheral Neuropathy, Pneumonia and Spinal Stenosis. According to Incident/Accident Reports on 5-4-13 and 6-5-13 Tenant #3 paged for assistance and was found on the floor. Tenant #3 did not sustain any injuries with the incidents on 5-4-13 and 6-5-13. According to an Incident/Accident Report dated 6-28-13, Tenant #3 had tried to go to the bathroom and missed the chair. Tenant #3 did not sustain any injuries with the fall on 6-28-13. On 7-12-13 staff answered Tenant #3's page and observed Tenant #3 on the floor in the living room. Tenant #3 was transferring to the recliner and lost balance. Tenant #3 hit Tenant #3's forehead and knee. There were no visible injuries to the head. Tenant #3 had lacerations to the right knee and left elbow. The elbow and knee were bandaged. There was no documentation of the falls in Nurses Notes. Nurse reviews were not completed as needed regarding Tenant #3's falls. Nurse reviews were not completed as needed.

Review of tenant files indicated nurse reviews were not completed as needed.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

C. Service Plans

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Three tenant files (Tenants #1, #2 and #3) were reviewed.

Tenant #1's file was reviewed. Tenant #1's service plan was updated on 5-22-13, 6-13-13, 7-5-13 and 7-8-13. On 5-22-13 the service plan reflected Tenant #1's confusion level appeared to be increasing during the evening hours. On 6-13-13 the service plan reflected every two hour checks. On 7-5-13 the service plan indicated Tenant #1 had increased forgetfulness, was unsure of where home was and Tenant #1's confusion level was increasing. On 7-8-13 the service plan reflected bells were placed on the door, Tenant #1 was to remain in sight of staff/family at all times when out of the apartment. Nurse reviews were not completed as needed when these changes were added to the service plan. The updates to the service plan occurred without nurse reviews.

Tenant #2's file was reviewed. Review of Incident/Accident Reports indicated on 5-3-13 Tenant #2 called 911 from the nurses' desk because Tenant #2 wanted to see family. On 5-6-13 Tenant #2 called 911 from the nurses' station phone. Tenant #2 wanted to see family and denied other reasons for a hospital transfer. On 5-30-13 Tenant #2 called 911 while staff was helping with a different tenant. Tenant #2 denied specific symptoms or a reason for calling. Tenant #2 was taken to a hospital for treatment. Tenant #2's service plan did not reflect Tenant #2's behavior regarding calling 911 and interventions related to the behavior. According to a Nurses' Progress Note dated 6-30-13, Tenant #2 was diagnosed with a UTI on 5-7-13 and was started on Bactrim, which was then switched to Cipro. Tenant #2 also had a groin rash and was started on Mycolog ointment to groin rash twice daily then as needed. On 5-31-13 Tenant #2 was started on Cedfinir for an URI and Hydrocodone 5-325 mg as needed for abdominal pain. The service plan was not updated to reflect the UTI, rash, URI and adnominal pain. The service plan did not reflect the identified needs of Tenant #2.

Tenant #3's file was reviewed. According to Incident/Accident Reports on 5-4-13 and 6-5-13 Tenant #3 paged for assistance and was found on the floor. Tenant #3 did not sustain any injuries with the incidents on 5-4-13 and 6-5-13. According to an Incident/Accident Report dated 6-28-13, Tenant #3 had tried to go to the bathroom and missed the chair. Tenant #3 did not sustain any injuries with the fall on 6-28-13. On 7-12-13 staff answered Tenant #3's page and observed Tenant #3 on the floor in the living room. Tenant #3 was transferring to the recliner and lost balance. Tenant #3 hit Tenant #3's forehead and knee. There were no visible injuries to the head. Tenant #3 had lacerations to the right knee and left elbow. The elbow and knee were bandaged. There was no documentation of the falls in Nurses Notes. The service plan did not reflect Tenant #3's falls and interventions regarding the falls.

Review of tenant files indicated service plans were updated without nurse reviews and service plans did not reflect the identified needs of tenants.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan. (IAC r. 481-69.26(3)(b))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))