IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED

Complaint Intake #: 45997-I

December 6, 2013

Ms. Rhonda Allen, Program Manager
Parkers Place Retirement
707 Hwy 57
Parkersburg, IA 50665

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - PARKERS PLACE RETIREMENT
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Allen:

I. Final Complaint/Incident Investigation Report – Parkers Place Retirement, Parkersburg, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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, following an investigation by DIA on **November 12, 2013.** The Report notes Regulatory Insufficiency in the area(s) of: Policies and Procedures.

Parkers Place Retirement ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, the Program failed to follow their policy regarding alarms. A tenant with dementia eloped and was at risk for injury while gone from the building.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of **six hundred and fifty dollars ($650)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Plan of Correction (POC) submitted on December 1, 2013, has been reviewed and will constitute the final POC related to the on-site visit of November 12, 2013.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of notice or service of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Rhonda Allen, Program Manager
Parkers Place Retirement
707 Hwy 57
Parkersburg, Iowa 50665

Complaint/Incident Intake #:

45997-I

Date of Complaint/Incident Investigation:

November 12, 2013

Monitor(s):

Maribeth Freland RN

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:	20
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	21
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	30

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:

Policies and Procedures

Complaint/Incident Allegation: It was reported a cognitively impaired tenant eloped from the building without staff member knowledge.

- Monitoring Observation: The program identified two cognitively impaired tenants who exhibited wandering behaviors (Tenants #1 and #2) and one tenant who exhibited exit seeking behaviors (Tenant #2).

  During interview, Staff #1, universal worker, identified Tenant #1 and Tenant #2 as exhibiting wandering behaviors and identified Tenant #2 as the only tenant exhibiting exit seeking behaviors. Staff #1 reported Tenant #2 had exhibited exit seeking behaviors multiple times per shift on a routine basis during the first week of residing at the program. Tenant #2 would go to the exit doors in the secured dementia unit, push down on the egress bar which would activate an audible alarm and send notification that someone was attempting to open a door in the unit, continue to push on the bar which would eventually release the lock on the door and attempt to leave the unit if staff members did not intervene. Staff #1 reported Tenant #2 had begun to show much less exit seeking behaviors since the first week following admission.

  The secured memory care unit had two doors which exited into the interior general population area of the building. Both doors were secured and alarmed with an audible alarm system. The audible alarm system included a keypad that allowed a

code to be put in to bypass the audible alarm and the 15 second egress function when opening the door. The alarm would not sound if the code is correctly inputted; however, a message was sent to pagers carried by staff members reporting the door had been opened. If the code was not put in and the door bar was pushed to open the door, an audible alarm sounded and a message was sent to each staff members' pager that an unauthorized attempt to exit from the dementia unit was in process. If the bar was released, the audible alarm would cease sounding and the door remained locked. If the bar was pushed continually, the door lock would release in 15 seconds, allowing egress from the building whether authorized or unauthorized. The 15 second egress function allowed emergency exit from the locked unit in case of fire. The door itself contained the words "For emergencies, push egress bar for 15 seconds and the door will automatically release". The audible alarm would continue to sound and a message would be sent to staff members' pagers notifying them of the door being opened. When the door was shut after opening, the lock and alarm system automatically reengaged.

The general population area had three exit doors. The exit doors in the general population area were not alarmed but were attached to the pager notification system so each time one of the doors opened in the general population area a message was sent to each staff members' pager.

All universal workers carried a pager and a portable cellular phone so if the universal workers are unable to timely respond to a pager notification of a door opening in either the dementia unit or the general population area they could call to the others for assistance.

The program's policy, titled Elopement Policy, directed staff members to check alarms promptly should any door alarm sound. Staff members were to check thoroughly inside and outside should an alarm be triggered. If a potential elopement was identified and a tenant was not visualized, all tenants were to be accounted for, a search inside and outside for the missing tenant should be initiated and law enforcement should be contacted if the tenant was not found following the search.

Tenant #1, an 89 year old, was admitted to the program on 10-31-13 and currently resided in the secured dementia unit. Tenant #1 had diagnoses of: Dementia, Hypertension, Depression and a History of Trans Ischemic Attacks. Tenant #1 scored 5 on the Global Deterioration Scale (GDS) completed on 10-26-13, which indicated moderately severe cognitive decline. Tenant #1's service plan documented Tenant #1 was independent with transfers and ambulation without use of any device. The same service plan documented the Tenant wandered frequently, often going into others' apartments but had not exhibited exit seeking behavior. Tenant #1's clinical record indicated staff members had been able to easily redirect Tenant #1 from wandering throughout the secured dementia unit. Tenant #1 had made no attempts to exit from the unit and had not eloped from the building since admission.

Tenant #2, an 81 year old, was admitted to the program on 10-21-13 and resided in the secured dementia unit. Tenant #2 had diagnoses of: Parkinson's Disease, Dementia, Depression, Chronic Alcohol Abuse and a History of Seizure Disorder. Tenant #2 was admitted from an inpatient stay at a Behavioral Unit following an acute episode of depression with accompanying uncontrolled agitation. After

medication adjustments and control of the acute depression, Tenant #2 moved into the assisted living secured dementia unit for close supervision to assure his/her safety. Tenant #2 scored a 4 on the GDS completed on 10-18-13, indicating moderate cognitive impairment. According to Tenant #2's service plan, Tenant #2 was independently ambulatory without devices.

Tenant #2 had no history of elopement from the building but often went to the doors attempting to leave the secured dementia unit to go home and to find his/her deceased spouse. During interview with Staff #1, universal worker, she reported Tenant #2 had exhibited exit seeking behaviors multiple times per shift on a routine basis during the first week of residing at the program. Tenant #2 would go to the exit doors in the secured dementia unit, push down on the egress bar which would activate an audible alarm and send notification that someone was attempting to open a door in the unit, continue to push on the bar which would eventually release the lock on the door and attempt to leave the unit if staff members did not intervene. Tenant #2 was still able to read the directions on the door to push the egress bar for 15 seconds for emergency release.

On 10-24-13 at approximately 6:59 p.m., staff member pagers received notification that the south dementia unit exit door had been opened. According to the Alarm Response Report, the south dementia unit exit door egress bar had been pushed to release the lock using the 15 second egress. The alarm sounded for 22 seconds audibly and sent a message to each staff members' pager. After 22 seconds the south dementia unit exit door was closed and the lock/alarm reengaged. The same report indicated the program's main entrance in the general population area was opened at 7:00 p.m. and was reengaged 6 seconds later.

According to the program's internal investigation and incident report, at 7:25 p.m., Tenant #2's friend came into the secured memory care unit reporting Tenant #2 was across the road at a bar having a beer and had been expressing a wish to go home. Tenant #2's friend indicated he/she had contacted Tenant #2's family member to come get Tenant #2 from the bar. Staff #2, universal worker, contacted theProgram Manager and registered nurse (RN) to report the incident; then Staff #2 went across the road to get Tenant #2. At that time, Tenant #2's family member was already coming out of the bar with Tenant #2 so Staff #2 allowed the family member to return Tenant #2 to the dementia unit. Tenant #2 returned to the assisted living at 7:35 p.m. on 10-24-13. Tenant #2 was dressed in long pants, long sleeved shirt, jacket, socks and shoes.

The program had no documentation indicating a head count was done as required by the program's policy to account for all other tenants after notification that Tenant #2 had eloped from the building. During interview, the Program Manager reported when staff members called to report the incident they made the comment "everyone is okay" so she had assumed a head count had been done. (The monitor attempted to contact Staff #2 who was working in the dementia unit on the evening shift on 10-24-13. Staff #2 did not return the monitor's phone call.) During interview, Staff #3 reported a head count was done with all other tenants accounted for when Tenant #2's elopement had been identified.

During interview, Tenant #2's friend reported he/she arrived at the bar across the road from the assisted living program at approximately 6:30 p.m. At approximately 7:00 p.m. Tenant #2 entered the bar and came over to his/her friend. Tenant #2 said "I want to go home." The friend told Tenant #2 "you live across the street" and Tenant #2 responded, "no I mean home". Tenant #2's friend bought Tenant #2 a beer and assured other bar patrons supervised Tenant #2. Then the friend drove to Tenant #2's family members house to notify the family member of Tenant #2's whereabouts. Tenant #2's family member was not home so the friend went back to the bar and was able to get the family member's telephone number. The friend called Tenant #2's family member. After assuring Tenant #2's family member was coming to pick up Tenant #2, the friend went across the road to alert the assisted living staff members that Tenant #2 was at the bar. Tenant #2's friend indicated Tenant #2 was at the bar about 30 minutes.

According to a written statement collected during the program's internal investigation, Staff #3, who had a hire date of 10-8-13 and who was being oriented by Staff #2 on the evening of 10-24-13, reported she observed Tenant #2 in the secured dementia unit at approximately 7:00 p.m. Immediately following, Staff #3 accompanied Staff #2 to another tenant's apartment to assist the tenant with a shower. Staff #3 reported she left the apartment while the shower was being given to check on Tenant #2. Staff #3 noted Tenant #2's apartment door was closed so she assumed Tenant #2 had gone to bed but did not actually check the apartment to assure Tenant #2's whereabouts. Staff #3 reported at 7:25 p.m. Tenant #2's friend notified the program that Tenant #2 had left the assisted living and gone to the bar. The incident report did not address whether the door alarm sounded, if Staff #3 heard the alarm, if the alarm sent a message to the pager carried by staff and whether Staff #3 responded in any way to the alarm. During interview, Staff #3 reported she did not hear the audible alarm as she was in another tenant's apartment with the shower running but a message did come across on the pager she was carrying. Staff #3 reported she was still training and did not know how to use the pager very well yet so when the message came across she hit the wrong button so was unable to tell what the page was for. Staff #3 verified she was unaware of Tenant #2's elopement until Tenant's friend came to the program and reported Tenant #2 was across the road at the bar.

According to the incident report, which had been completed by Staff #2, Staff #3 completed a visual check noting Tenant #2 was in the dementia unit at 7:00 p.m. on 10-24-13. After the visual check, Staff #2 and Staff #3 went to another tenant's apartment, which was located in the dementia unit, to assist the other tenant with a shower. Staff #3 left at 7:15 p.m. to check on Tenant #2 but did not actually see Tenant #2. At 7:25 p.m. Tenant #2's friend alerted staff members that Tenant #2 was across the street having a beer and wanted to go home. The incident report did not address whether the door alarm sounded, if staff members heard the alarm, if the alarm sent a message to the pager carried by staff and whether staff members responded in any way to the alarm. Staff #2 refused to interview with the Program Manager during the program's internal investigation and did not return the monitor's telephone request for interview.

According to an interview obtained during the program's internal investigation into the incident, Staff #4, a universal worker, was working in the general population unit on the evening of 10-24-13. Staff #4 indicated she could not remember if the audible

alarm sounded but she did get a page indicating the south dementia unit door and the main entrance door had been opened. Staff #4 indicated she was assisting a tenant clean up following an incontinent bowel movement when the pager notified of the doors opening. Staff #4 reported she "finished up" with the other tenant then went to the main entrance. Staff #4 reported she visualized the door but did not check the outside perimeter. Staff #4 reported she went back to the dementia unit to check to see what was going on.

During interview, Staff #4 told the monitor that she did have a notification of both doors opening at approximately 7:00 p.m. but was busy with another tenant. Staff #4 reported she did not notify the other staff members by cellular phone that she was unable to immediately check on the door alarms. Staff #4 reported she "finished up" with the other tenant then went to the front main entrance. Staff #4 reported she saw no one at the entrance so she went to the dementia unit. Staff #4 reported when she got to the unit, Staff #2 and #3 told her that Tenant #2 had gotten out and went across the street to the bar. Staff #2 and #3 had not been notified that Tenant #2 was at the bar until 7:25 p.m., 25 minutes after Tenant #2's actual elopement. Staff #4 did not just ensure the other tenant's safety then check on the alarm. Staff #4 continued to care for the other tenant until all care was complete, then checked on the alarm approximately 25 minutes after the alarm sounded.

According to the investigation summary completed by the Program Manager, Staff #3, the universal worker who was completing orientation, had been carrying the pager on 10-24-13. Staff #3 had reported she did not know how to answer pages received on the pager. The Program Manager determined Staff #2 and #4, both "seasoned staff" did not follow the program's policy to answer all alarms when sounding promptly. The Program Manager terminated Staff #2 and #4's employment with the assisted living, citing failure to follow program policy which placed a tenant at a safety risk.

According to the State Climatologist, it was 38 degrees at 7:00 PM on 10-24-13 and partly cloudy with winds from the east at 4 miles per hour (mph) making the wind chill 36 degrees.

On 10-24-13 Tenant #2 appeared to have left the secured dementia unit at 6:59 p.m. by pushing on the egress bar for 15 seconds until the door lock released allowing exit from the unit. Tenant #2 appeared to have left the building through the front main entrance at approximately 7:00 p.m. Tenant #2 traveled through the program's parking lot and across Highway 57/Highway 14, which is a two lane highway with posed 45 miles per hour speed limit. Tenant #2 entered a bar that is located across the highway from the assisted living program.

After the elopement, the program initiated visual checks of Tenant #2 every 15 minutes which continued at the time of the on-site visit. All staff members attended an in-service on alarm response. Two way radios have been purchased and were now being carried by staff members for quick communication instead of the cellular phones.

Tenant #2's service plan addressed his/her wandering and exit seeking behaviors. The plan identified ways to redirect Tenant #2. The service plan was updated

appropriately following Tenant #2's elopement. On the day of the elopement, an orienting staff member who did not know how to use the pager system carried the only pager in the secured dementia unit. The orienting staff member also completed the visual checks of Tenant #2 and did not actually see Tenant #2 during the 7:15 p.m. check. The audible alarm system is believed to have sounded when Tenant #2 opened the dementia unit door for 22 seconds but none of the staff members were in a position to hear the alarm. Messages went to the pagers carried by Staff #3 and #4 when both the dementia unit door and the main entrance in the general population area were opened without authorization. Staff #2, #3 and #4 did not respond to the alarm in a prompt manner. The program's system failed to keep Tenant #2 from exiting the building without staff member knowledge or supervision. Tenant #2 was at risk for injury while gone from the building.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by the program. (IAC r. 481-67.2)