IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
46232-I

December 11, 2013

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

RE: Final Complaint/Incident Investigation Report, Parkers Place Retirement, Parkersburg, Iowa

Dear Ms. Allen:

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. The Program did not receive a regulatory insufficiency in the area of Policies and Procedures; therefore, a Plan of Correction was not required.

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 #:** 46232-I

Rhonda Allen, Manager
Parkers Place Retirement
707 Highway 57
Parkersburg, IA 50665

Date of Complaint/Incident Investigation:

November 21 and 25, 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:	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 – During the November 12, 2013 Incident Investigation ((45997-I) the program received a regulatory insufficiency in the area of Policies and Procedures.

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

A. Policies and Procedures

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

- Monitoring Observation: Tenant #1 eloped on 11-18-13 and the Program reported the elopement to the Department. Tenant #1 also eloped on 10-24-13 and the Department investigated on 11-12-13.

  Tenant #1, an 81 year old, was admitted on 10-21-13 and diagnoses included: Dementia with Agitation, Parkinson's Disease, Chronic Atrial Fibrillation with Pacemaker, Alcohol Abuse, Peripheral Vascular Disease, Carotid Endarterectomy, Hyperlipidemia, Depression, History of Cerebral Vascular Accident (2010) and History of Seizure Disorder. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit.

  The service plan indicated Tenant #1 was independent with ambulation and had a cane but rarely used it. The service plan indicated 15 minute visual checks were initiated on 10-24-13. On 11-19-13 the service plan was updated and reflected a wide gap alarm was placed on Tenant #1's apartment door. Visual checks every 15 minutes were continued and an audible alarm for the courtyard door (not tied to pagers) which would require checking and resetting the alarm would be placed. The

service plan reflected Tenant #1 was "cold natured" and wore a coat inside when cold. Tenant #1 would want heat turned up to keep the apartment warm. The service plan also reflected interventions if Tenant #1 attempted to leave the dementia unit. It indicated if Tenant #1 got through the secure doors to try and get Tenant #1 back in and call the Manager and registered nurse.

The Program consisted of a general population and a secured dementia unit attached by structure. The dementia unit had two exit doors that went into the interior of the general population. There was also one exit door that went to a courtyard. The courtyard had a fence with a gate and block retaining wall. The doors from the dementia unit to the general population were alarmed and secured. The doors were 15 second egress doors. The courtyard door was the northwest exit door. The northwest exit door had a wide gap transmitter that sent a page to staff pagers when opened. The northwest door did not have a delayed egress function. The courtyard had a block retaining wall and a fence with a gate. The gate was padlocked and staff had the key to the padlock. A wide gap transmitter was observed on Tenant #1's apartment door. The wide gap transmitter sent a page to the pager when the door was opened.

According to the Program's Elopement Policy, elopement was defined as a tenant with impaired decision making ability (GDS of four or greater) leaving the "Community" without supervision and posing a risk to self. Elopement differed from a walk in that the tenant was purposefully leaving and putting them at risk for falls, hyperthermia, hypothermia, traffic accident and assaults. Visual checks would be completed on tenants with confusion at or above a four on the GDS. The nurse would evaluate each tenant and provide staff with a list of the tenants to be checked.

The procedure indicated to watch for signs of wandering and confusion that might put the tenant at risk of elopement. If any door alarm sounded to check door alarms promptly, thoroughly check inside and outside areas triggered by the alarm. An incident report was to be filled out on any attempted elopement or any elopement. If a potential elopement occurred and the tenant was not seen, completely search the community checking all apartments, offices, closets, bathrooms and common areas. The Manager or Nurse would call the family to see if the tenant was with family. An outside search would also be completed. If the tenant was still not found the Manager or Nurse would notify local law enforcement. Staff would take guidance from law enforcement. The Manager or Nurse would notify the family once the tenant was found.

According to an Incident Report, the date of the incident was 11-18-13 and the time was 4:05 p.m. The location was the dementia unit. Police called at approximately 4:05 p.m. and stated Tenant #1 was walking around 4th street or 4th avenue. Police brought Tenant #1 back at approximately 4:15 p.m. and staff assisted Tenant #1 back to the dementia unit. Staff asked what door Tenant #1 went out and Tenant #1 pointed to the northwest exit. Tenant #1 said Tenant #1 climbed over the wall. Staff looked out the door and saw a chair pushed up against the retaining wall. Tenant #1 said Tenant #1 went out with the tenant who smoked. According to the incident report, Tenant #1 said it was cold out there. The incident report indicated family was notified.

According to Nurse's Notes dated 11-18-13 at 4:05 p.m., a phone call was received from the police department regarding a report that Tenant #1 was seen walking through a backyard. Nurse's Notes dated 11-18-13 at 4:15 p.m. indicated Tenant #1 arrived (at the Program) via a police officer. Tenant #1 was calm and was wearing a winter coat. Tenant #1 said it was cold outside. Tenant #1 was assisted back to the dementia unit without difficultly. When asked what door Tenant #1 went out of Tenant #1 pointed to the northwest exit and said Tenant #1 went out with the tenant who smoked. Tenant #1 stated Tenant #1 pushed a chair up against the wall and climbed up and over the wall. Tenant #1 was offered a cup of coffee and Tenant #1 accepted.

According to a nurse review completed on 11-20-13 (review of incident on 11-18-13), Tenant #1 had a wide gap transmitter placed on the apartment door. Family was looking into providing a private caregiver. There was extra staff in the dementia unit during the day and evening. Tenant #1 remained on every 15 minute checks.

According to a statement from the Manager, on 11-18-13 at approximately 4:30 p.m. she was notified Tenant #1 had left the Program at approximately 4:00 p.m. and was returned about 4:15 p.m. by the police department. The police department was notified of Tenant #1 walking behind the building at approximately 4:05 p.m. Tenant #1 told staff that Tenant #1 went out the doors to the courtyard with another tenant who smoked. Tenant #1 pushed a lawn chair to the fence and climbed over. Staff was aware the tenant who smoked went out the door but was not aware Tenant #1 went out with the other tenant. Tenant #1 was on 15 minute visual checks and the checks were completed correctly. Tenant #1 was wearing a coat and shoes appropriate for the weather and there was no negative outcome.

The Manager said she received a telephone call at approximately 4:30 p.m. and Staff #2 reported Tenant #1 had eloped and police had brought Tenant #1 back at 4:15 p.m. Staff #1 had seen Tenant #1 shortly before 4:00 p.m. Staff tried to figure out which door Tenant #1 went out and Staff #2 asked Tenant #1. Tenant #1 pointed to the northwest door and said Tenant #1 had climbed the wall. Tenant #1 did not sustain any injuries. Tenant #1 ambulated independently. After the elopement a wide gap alarm was put on Tenant #1's apartment door, it was planned to get quotes on fencing to put up a fence with no foot holds, it was planned to have an audible alarm on the northwest exit door and staff would have to actually reset the door. A staff was added on first shift and second shift. On 11-22-13 Tenant #1's family was going to have a private caregiver on second shift. The Manager said the Program could keep Tenant #1 safe.

The Health Care Coordinator was not involved with the incident with Tenant #1 and Staff #2, a licensed practical nurse (LPN), was involved. Since the elopement a wide gap alarm was placed on Tenant #1's apartment door, two staff members were assigned to the dementia unit and family was looking into providing someone for evenings and weekends. The Health Care Coordinator said the Program could keep Tenant #1 safe.

According to the Manager's interview of Staff #1, visual checks were followed, the policies and procedure when the visual checks were done was followed. The last time Staff #1 saw Tenant #1 was just before 4:00 p.m. Staff #1 saw Tenant #1 in the

hallway by the common area, she then saw Tenant #2 heading down the hallway and Staff #1 knew Tenant #2 was going out the northwest door to smoke. Staff #1 saw the page for the northwest door. Staff #1 found out Tenant #1 was not present at approximately 4:05 to 4:10 p.m. Staff #1 said Staff #2 came back and wanted to know when Staff #1 had last checked on Tenant #1 and wanted to know if Tenant #1 was there. Tenant #1 was returned by police around 4:10 p.m. to 4:15 p.m.

Staff #1 worked in the dementia unit at the time of the elopement. She said at approximately 4:00 p.m., before giving 4:00 p.m. medications Tenant #1 was seated in the common area watching a movie. Just about 4:00 p.m. Tenant #1 walked toward Tenant #1's apartment. Staff #1 got the supplies and medications ready. Tenant #2 smoked outside frequently and exited using the northwest door. At that time Tenant #2 had just walked past her. A page came across for the northwest door, she cleared it and did not check the door as she figured it was Tenant #2 as Tenant #2 was the only one who used the door. Staff #1 started administering medications and Staff #2 called on the walkie talkie and asked where Tenant #1 was and said Tenant #1 was found downtown. Staff #1 and Staff #2 checked Tenant #1's apartment and then checked all the tenant apartments and the courtyard. Tenant #1 was not found. Tenant #1 was returned to the Program and Staff #2 brought Tenant #1 back to the dementia unit. Tenant #1 sat and had some coffee. Staff #1 and Staff #2 checked all the doors and all alarms worked. Tenant #1 was asked how Tenant #1 got outside and Tenant #1 said Tenant #1 followed Tenant #2 outside, pushed a lawn chair to the wall and climbed over the wall. Staff observed a chair by the wall in the courtyard. Staff #2 called the Manager and maintenance staff that came out and removed the furniture from the courtyard. Tenant #1 was wearing loafers, socks, jeans and a long sleeved shirt. Tenant #1 ambulated independently and had a cane but did not use it. The time from when Tenant #1 was last seen until when Staff #2 called was not more than 15 minutes. Tenant #1 did not have any injuries, was a little cold but was not upset. Staff #1 did not take vitals. Staff #1 said previously Tenant #1 had gotten out of the dementia unit; however, did not leave the building that time. Staff #1 could not recall the date of the incident. Staff #1 said Tenant #2 smoked frequently and estimated every 10 minutes. She had never seen anyone else go to the northwest door and was used to it opening and being Tenant #2. Now she was checking and ensuring it was Tenant #2 outside. Staff #1 filled out an incident report and Staff #2 called the family. Staff #1 said she had been trained on the doors and pagers. Walkie talkies were used for staff to radio back and forth.

Staff #2, an LPN, said at approximately 4:00 p.m. she received a telephone call from the police department regarding a report of Tenant #1 in someone's backyard. After the police officer called, Staff #2 went to the dementia unit and Staff #1 and Staff #2 searched apartments, called the staff in the general population and the courtyard area was checked. Police escorted Tenant #1 back to the Program at 4:15 p.m. Tenant #1 had a winter coat on and said it was cold outside. The police officer left and Staff #2 escorted Tenant #1 back to the dementia unit. Staff #2 talked to Staff #1 and they went through the pages and tried to figure out what door Tenant #1 went out. Staff #1 told Staff #2 she did the 15 minute checks. Staff #2 asked Tenant #1 and Tenant #1 pointed to the northwest door and said Tenant #1 went out with the tenant who smoked (Tenant #2). Tenant #1 said Tenant #1 climbed on the chair and over the wall. Staff #2 notified the Manager and the Manager notified the family. Tenant #1 did not have any complaints and communicated well with Staff #2. Tenant #1 did not

complain of pain. Vital signs and an assessment of Tenant #1 after the incident were not completed. Since the elopement a wide gap alarm was put on Tenant #1's apartment door. Staff #2 said Tenant #2 smoked approximately every 10 to 15 minutes; however, it did vary.

Tenant #1 had visual checks every 15 minutes. On 11-18-13 the documentation indicated Tenant #1 was visually checked at 3:00 p.m., 3:15 p.m., 3:30 p.m., 3:45 p.m. and 4:00 p.m. At the time of the investigation the visual checks every 15 minutes were continued and included, the time of the check, Tenant #1's location and staff initials. Review of the checks indicated the checks were consistently documented as completed.

Alarm Response Report records were reviewed. The Manager indicated the time on the computer was off by about 45 minutes. The time of the computer was behind actual time. The records indicated the northwest exit door alarmed at 3:11:58 p.m. on 11-18-13. The time it was cleared was 3:12:05 p.m. (seven seconds). If the computer was behind 45 minutes that would add 45 minutes to time of 3:11:58 p.m. which would be approximately 3:56 p.m. It could not be determined if that was when Tenant #1 went out; however, Staff #1 said Tenant #1 was visualized just before 4:00 p.m. and when asked by staff what door Tenant #1 exited, Tenant #1 pointed to the northwest door.

Law enforcement records were obtained. The records indicated a report was received at 4:04 p.m. that Tenant #1 was walking in a person's backyard. The report indicated at 4:12 p.m. Tenant #1 was back at the Program.

According to an In-Service/Training Program document, on 10-30-13 training was held regarding elopement policy and pager training. The objective was to reinforce policy and go over situations.

Weather conditions were provided by the State Climatologist for two locations, Waterloo (east of Parkersburg) and Iowa Falls (west of Parkersburg). According to the State Climatologist on 11-18-13 at 4:00 p.m., the weather in Waterloo was as follows: temperature 39 degrees, winds from the northwest with gusts to 21 miles per hour (mph), the wind chill was 31 degrees, clear skies and no precipitation. The weather in Iowa Falls was as follows: temperature 41 degrees, winds from the west at 7 mph, the wind chill was 36 degrees, clear skies and no precipitation.

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

The procedure for Elopement/Missing Tenant was not followed regarding responding to door alarms and thoroughly checking inside and outside areas triggered by the alarm.

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

- Monitoring Observation: According to the Program's Incident Report policy, staff would immediately notify the Nurse/Manager if a tenant became ill, had fallen, unusual behaviors, upon identification of bruising, abrasions or skin tears, if the tenant was sent out by ambulance or any other event occurred which was a change

from the tenant's normal health, functional or cognitive status. An incident report would be completed by the Health Care Coordinator, person in charge or Manager. The Health Care Coordinator was responsible to follow up with a nurse review within 24 hours of the incident which would be documented in the tenant's (healthcare) chart.

Staff #1 said previously Tenant #1 had gotten out of the dementia unit; however, had not left the building that time. Staff #1 said this occurred one time but she could not recall the date of the incident. The Health Care Coordinator said there was one time where Tenant #1 came out of the dementia unit door into the general population but was not out of the building. An incident report was not completed related to it.

Tenant #1's file was reviewed and there was no documentation related to the incident. Incident reports for Tenant #1 were reviewed and an incident report was not found related to the incident. Tenant #1 had elopements on 10-24-13 and 11-18-13. Per interviews Tenant #1 left the dementia unit and went into the general population. An incident report was not completed. A nurse review was not completed related to the incident within 24 hours as required by policy.

An incident report was not completed related to the incident and a nurse review was not completed in Tenant #1's file related to the incident.

Policies and procedures were not followed regarding Tenant #1's elopement on 11-18-13; however, on November 21 and 25, 2013, the DIA investigated an elopement when Tenant #1 left the building on October 24, 2013. The program had not yet received the report regarding this incident and did not have an opportunity to develop a plan of correction. Therefore, while a deviation from the 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.

B. Nurse Review

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

- Monitoring Observation: Tenant #1's file was reviewed.

  According to an Incident Report, the date of the incident was 11-18-13 and the time was 4:05 p.m. The location was the dementia unit. Police called at approximately 4:05 p.m. and stated Tenant #1 was walking around 4th street or 4th avenue. Police brought Tenant #1 back at approximately 4:15 p.m. and staff assisted Tenant #1 back to the dementia unit. Staff asked what door Tenant #1 went out and Tenant #1 pointed to the northwest exit. Tenant #1 said Tenant #1 climbed over the wall. Staff looked out the door and saw a chair pushed up against the retaining wall. Tenant #1 said Tenant #1 went out with the tenant who smoked. According to the incident report, Tenant #1 said it was cold out there. The incident report indicated family was notified.

According to Nurse's Notes dated 11-18-13 at 4:05 p.m., a phone call was received from the police department regarding a report that Tenant #1 was seen walking through a backyard. Nurse's Notes dated 11-18-13 at 4:15 p.m. indicated Tenant #1 arrived (at the Program) via a police officer. Tenant #1 was calm and was wearing a winter coat. Tenant #1 said it was cold outside. Tenant #1 was assisted back to the dementia unit without difficultly. When asked what door Tenant #1 went out of Tenant #1 pointed to the northwest exit and said Tenant #1 went out with the tenant who smoked. Tenant #1 stated Tenant #1 pushed a chair up against the wall and climbed up and over the wall. Tenant #1 was offered a cup of coffee and Tenant #1 accepted.

According to a nurse review completed on 11-20-13 (review of incident on 11-18-13), Tenant #1 had a wide gap transmitter placed on the apartment door. Family was looking into providing a private caregiver. There was extra staff in the dementia unit during the day and evening. Tenant #1 remained on every 15 minute checks.

Weather conditions were provided by the State Climatologist for two locations, Waterloo (east of Parkersburg) and Iowa Falls (west of Parkersburg). According to the State Climatologist on 11-18-13 at 4:00 p.m., the weather in Waterloo was as follows: temperature 39 degrees, winds from the northwest with gusts to 21 mph, the wind chill was 31 degrees, clear skies and no precipitation. The weather in Iowa Falls was as follows: temperature 41 degrees, winds from the west at 7 mph, the wind chill was 36 degrees, clear skies and no precipitation.

Staff #1 and Staff #2 said Tenant #1's vital signs were not taken after Tenant #1 eloped. An assessment of Tenant #1 was not completed after the elopement. Tenant #1 climbed a retaining wall and left the courtyard. Upon return to the Program Tenant #1 did not voice any complaints but did indicate it was cold outside. A nurse review was not completed as needed.

Staff #1 said previously Tenant #1 had gotten out of the dementia unit; however, had not left the building that time. Staff #1 said this occurred one time but she could not recall the date of the incident. The Health Care Coordinator said there was one time where Tenant #1 came out of the dementia unit door into the general population but was not out of the building.

Tenant #1's file was reviewed and there was no documentation related to the incident. Tenant #1 had elopements on 10-24-13 and 11-18-13. Per interviews Tenant #1 left the dementia unit and went into the general population. A nurse review was not completed as needed.

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))