IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 45985-I

December 16, 2013

Mr. Mike Early, Manager
Gardens at Jefferson Assisted Living
1000 West Washington Street
Jefferson, IA 50129

RE: Final Complaint/Incident Investigation Report – Gardens at Jefferson Assisted Living, Jefferson, IA

Dear Mr. Early:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 5, 2013, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Mike Early, Manager
The Gardens at Jefferson Assisted Living
1000 West Washington Street
Jefferson, IA 50129

Complaint/Incident Intake #: 45985-I

Date of Complaint/Incident Investigation:

December 5, 2013

Monitor(s):

Lori Miner, RN BSN

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:	29
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	31
TOTAL census of Assisted Living Program	31

Program History – The program received regulatory insufficiencies in the areas of Medications, Policy and Procedure and Staffing during this certification period.

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

A. Life Safety

Complaint/Incident Allegation: The program reported Tenant #1 eloped.

- Monitoring Observation: Tenant #1, a 90 year-old, was admitted on 3-6-08 and had diagnoses of: Benign Prostatic Hypertrophy, Dementia, Hypertension, and Osteoarthritis. Tenant #1 had been staged at five on the Global Deterioration Scale (GDS) since 3-6-12. A GDS of five indicated moderately severe cognitive decline. Tenant #1 resided at the program with the spouse.

  On 10-24-13, Tenant #1 was returned to the program by an off-duty staff member, Staff #1, who was about a half mile from the program and saw Tenant #1 walking. Staff #1 offered Tenant #1 a ride back to the program which was accepted. Tenant #1 was returned to the program at approximately 5:00 p.m. Until Tenant #1 was returned, the program had no knowledge that Tenant #1 was not in the building.

  When Tenant #1 was returned to the program, the Registered Nurse (RN) completed evaluations of function, cognition, and health. Tenant #1 was observed to be dressed with a sweater, shirt, and t-shirt, as well as jeans, socks, and shoes. The temperature outside was approximately 47 degrees. The service plan was updated to include interventions for elopement risk including frequent checks which were documented. Tenant #1 was seen by a physician on 10-25-13 according to the nurse's notes.

  Tenant #1 was discharged from the program voluntarily with the spouse on 11-11-13.

The program conducted an investigation, and Tenant #1 was last known to be seen in the building at approximately 4:15 p.m. The Activity Coordinator reported she left the building at approximately 4:15 p.m. and Tenant #1 was sitting with the spouse at a dining room table. The Gardens at Jefferson has all doors alarmed with an audible alarm system.

Staff #1, who found Tenant #1, reported she had worked until 2:00 p.m. on 10-24-13. Staff #1 reported Tenant #1's spouse was not having a good day and Tenant #1 seemed more stressed. Most of the time Tenant #1 and the spouse spent time in the common areas of the building, the dining room and lobby, which were near the main entrance. Staff #1 stated Tenant #1 did not exit-seek and was not exit-seeking on 10-24-13. Staff #1 reported Tenant #1 did not appear to have any ill effects from leaving the program when she picked up Tenant #1.

Staff #1 reported the door alarms have always worked, and an audible alarm sounded when the door was opened. Door alarms were checked routinely.

Staff #2 was interviewed and stated she was working from 2:00 p.m. to 10:00 p.m. on 10-24-13. Before 4:00 p.m., Tenant #1 and the spouse were sitting in the dining room. Staff #2 reported the spouse was especially argumentative on 10-24-13. At about 4:00 p.m. Staff #2 reminded Tenant #1 it was close to dinner time. Staff #2 went on to pick up trash and start laundry. Later, Staff #2 saw the spouse sitting by self. Staff #2 did not find it unusual because Tenant #1 used the public restroom independently. Tenant #1 was not exit-seeking.

Staff #2 reported the door alarms always worked and did not recall re-setting the alarms on 10-24-13. Door alarms were reported to be checked routinely.

Staff #3 reported Tenant #1 usually sat with the spouse in the public areas of the building after lunch. Tenant #1 used the public restroom independently and could get back to the common area without prompting. Tenant #1 was not exit-seeking. Staff #3 reported there were no other tenants who had gotten out of the building without staff knowledge. The exit doors were alarmed.

The Manager reported he recalled attempting to reset the alarm to the main entrance at approximately 1:30 p.m. Resetting the alarm was a three-step process. The keypad in the hallway is first, then the keypad at the main entrance is reset, the final step in the final reset in the hallway. The Manager did not recall if all three steps were followed. The hallway key pad has a message that is displayed when the alarm is reset. The Manager reported it was a busy day and that the program also considered the possibility that Tenant #1 walked out behind a guest exiting the building. The Manager also stated many of the tenants have the code to the keypad to exit the building.

Maintenance provided documentation of weekly door alarm checks which was current at the time of the elopement. The checks were changed to daily after the elopement.

The Manager indicated the program installed a secondary alarm system to notify staff when the three-step reset process had not been completed. The alarm system was demonstrated and was in working order. A sign was also placed on the door to the main entrance to remind persons exiting the building to be aware of tenants who may be following close behind.

Tenant #1 eloped from the program on 10-24-13. Tenant #1 had no history of exit-seeking. Tenant #1 returned to the program with no documentation of injury. The program followed up with evaluations and service plan update. Tenant #1 was seen by a physician the next day. The program instituted frequent checks of Tenant #1 and the frequency that the alarm system was checked was also increased. A secondary alarm system was installed and a sign was placed on the door to ask those exiting the building to watch for tenants who might leave with them. The program completed an investigation. The program was unable to determine whether or not Tenant #1 walked out of the program following another guest.

- Regulatory Insufficiency: None noted.