IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
46401-I

January 30, 2014

Mr. Jeffrey Schmidt, Executive Director
Aase Haugen Assisted Living
8 Ohio Street
Decorah, IA 52101

RE: Final Complaint/Incident Investigation Report, Aase Haugen Assisted Living, Decorah, Iowa

Dear Mr. Schmidt:

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, following an investigation by DIA on **January 15, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Staffing.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to 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: **Complaint/Incident Intake #:** 46401-I

Jeffrey Schmidt, Executive Director
Aase Haugen Assisted Living
8 Ohio Street
Decorah, IA 52101

Date of Complaint/Incident Investigation:

January 15, 2014

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:	18
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	18
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	26

Program History – The program received insufficiencies related to operating unlicensed kitchens within the assisted living program, failure to alarm all doors within the dementia specific unit and failure to require all persons transporting tenants to possess adequate licensure during the course of the recertification monitoring visit completed on 8-14-13.

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 exited the building and the alarm sounded. The tenant fell, unobserved, and was transported to the Emergency Room (ER).

- Monitoring Observation: Tenant #1, a 91 year old, admitted on 9-11-13 and diagnoses included: Advanced Dementia. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. According to a service plan dated 10-8-13, Tenant #1 received assistance with two showers weekly and hair wash, reminders to shave and set-up and cue for Activities of Daily Living and toileting, was independent in mobility without using assistive devices, independent in eating and dependent with staff assistance with medications.

  According to an Elopement Resident Form dated 11-29-13, Tenant #1 had last been seen at 2:30 a.m. According to Interdisciplinary Progress Notes dated 11-29-13 at 4:05 a.m., the Director of Nursing (DON) received a call from an LPN who worked in the nursing home.

The LPN stated she noticed an ambulance outside around 3:25 a.m. At approximated 4:00 a.m. a police officer came into the facility to alert them Tenant #1 had been found outside by a passerby. Tenant #1 had apparently fallen and hit his/her head. Tenant #1 had been taken by ambulance to the ER. At 4:30 a.m. Tenant #1's family arrived, was informed of the transfer and immediately left for the ER. At 6:57 a.m. the DON called the ER for an update. Tenant #1 was doing well and family was in attendance. The DON was informed Tenant #1 arrived wearing a tee shirt, plaid flannel shirt, shoes and socks. Tenant #1 had an abrasion on head and a superficial laceration from the monitoring watch on Tenant #1's arm. Areas were cleaned and dressed. Vital signs on admission were stable: Temperature 97 degrees, blood pressure 120-130/50-60, pulse 80-90 and saturated oxygen level at 96%. The ambulance had been called out at 3:39 a.m. and arrived on scene at 3:44 a.m. Tenant #1 returned to the Program at 8:00 a.m. smiling and laughing, monitoring bracelet on arm. Tenant #1 was assisted to commons room for nourishment and frequent checks were started.

According to a written statement by the LPN, at approximately 3:35 a.m. to 3:45 a.m. she noticed an ambulance going by the windows. At approximately 4:00 a.m. a police officer came to report Tenant #1 had gotten outside. Tenant #1 was found outside by someone who was going to work. Tenant #1 had fallen and hit his/her head and was taken to the ER for treatment.

A statement written by Staff #1 indicated she made rounds at 2:00 a.m. and all tenants were sleeping in their beds. At 2:30 a.m. she thought she looked at the clock and then sat down for a while in the blue rocking chair. At that point she heard the alarm and got up to shut the alarm off so it wouldn't wake the tenants. She then looked out the door to the street and didn't see anyone, then went to Tenant #1's apartment and Tenant #1 wasn't there. She then looked at the AL door to check between AL and memory care for Tenant #1. There was no sign of Tenant #1. She looked down the AL hall and no one was there so she went back to memory care. She checked Tenant #1's room again, the living room and kitchen and no one was there. She looked out the door to the street and opened the door and yelled for Tenant #1. Then she saw the ambulance across the street. She went back in and looked out all the doors. She went to talk to the nursing home LPN but before she got there the LPN and a police officer were coming down and they told her what happened to Tenant #1.

According to the DON, at approximately 4:00 a.m., she received a call from the charge nurse in the nursing home who stated the police were there and Tenant #1 was going to the hospital. She came into the building and conducted a body check on every tenant in the unit with Staff #1. They went into Tenant #1's room and she had Staff #1 show her where Tenant #1 had been. Staff #1 stated she had fallen asleep. Staff #1 said she had made rounds at 2:30 a.m. The DON said the police were familiar with Tenant #1 due to calls from family when Tenant #1 resided at home. All alarmed doors were tested and worked; Staff #1 was terminated that morning.

Staff #2 said when she came to work at 6:00 a.m., Staff #1 told her "It's my fault" but didn't say what it was that was her fault. The DON and Staff #4 were there. Later Staff #1 said she fell asleep and Tenant #1 got out, fell and was at the ER. Tenant #1 returned later, was laughing and seemed okay. Tenant #1's face was scraped up. She remembered it was a very cold morning when she came to work.

Staff #3 said she received a phone call around 5:00 a.m. or 5:30 a.m. and was told Tenant #1 had eloped. A neighbor who was going to work came out and found Tenant #1 lying on the sidewalk. A call was made to 911 and an ambulance arrived and took Tenant #1 to the ER. Police came to the Program and notified staff. Tenant #1's head was bleeding and there was blood on the ground. Lacerations were on Tenant #1's arm where the monitoring watch was and on Tenant #1's face.

Staff #4 stated the DON called her on 11-29-13 at 4:45 a.m. and said there had been an elopement in memory care. An ambulance took Tenant #1 to the ER. Staff #4 came to the Program about 5:15 a.m. or 5:20 a.m. and the DON was talking to Staff #1 investigating what happened. Staff #1 was upset, crying and admitted she had fallen asleep. Staff #4 called the ER and was told Tenant #1 was wearing socks, shoes, short sleeve tee shirt and long sleeve flannel shirt and was wrapped in a bed quilt. She stated there were no exposure issues as Tenant #1's temperature was 97 degrees the entire time and Tenant #1 was being jovial in the ER. Tenant #1 returned around 7:45 a.m. with family. Tenant #1 was normal self, joking and happy.

According to a Disciplinary Action Form dated 11-29-13, Staff #1 was terminated for sleeping on duty and not following elopement procedures.

According to the DON, Staff #2, #3 and #4 there was enough staff to meet the needs of the tenants.

The Elopement/Missing Person Policy indicated to minimize risk of elopement of cognitively impaired tenants and identification of tenants that may wander there would be an implementation of an effective system to minimize the risk of elopement. A monitoring watch would be placed on those tenants that exhibited potential wandering/elopement potential. The monitoring watches were checked daily for placement and alarm doors in the dementia specific AL were checked weekly by maintenance. Documentation of the daily checks for the months of September through December 2013 and the weekly maintenance checks for the entire year of 2013 was provided. According to the policy when an elopement, when the door sounded universal workers were to respond promptly to the alarmed door. When only one staff was on the shift, staff was to check the west street exit door and call nursing home staff to come check the main dementia specific exit door and the courtyard door exit. If the tenant was not found local police would be notified to assist. The door alarm sounded and the system worked appropriately.

The Life Safety for Dementia Specific Program policy indicated an operating alarm was connected to each exit door in the dementia specific unit. A monitoring system was used in the dementia unit where all tenants were issued a monitoring alarm to be placed on their body. This alarm would activate the door alarm system when a tenant attempted to exit the facility unattended. Staff was trained and instructed to respond to exit door alarms when sounding and check for the possibility of a missing tenant.

The Staffing policy indicated the Program would maintain quality staffing that would meet the needs of the tenants. Sufficient trained staff would be available and awake 24 hours a day to the assisted living either directly or in conjunction with nursing home staff. All staff would know and be able to implement the Program's accident, fire safety and emergency policy. If the Program served one or more tenants with cognitive disorders or dementia, staff would be onsite and awake 24 hours a day.

A layout of the memory care was obtained. Tenant #1's apartment was located midway between the internal and external exit doors. The monitor observed the external exit door area. Outside the door was a cement slab that connected to a sidewalk that led to another sidewalk that went parallel along the street. It could not be determined the exact path Tenant #1 took as Tenant #1 was unobserved. Tenant #1 was found lying on the ground in a parking lot across the street from the building.

According to the State Climatologist, on 11-29-13 at the Decorah airport at 2:55 a.m. it was 14 degrees under clear skies and winds were calm.

An incident report was completed and the Department was notified appropriately.

Per review of Tenant #1's file, interviews, review of policies and observations, Tenant #1 exited the building, the alarm functioned but staff was asleep. The sounding of the alarm awoke Staff #1 who searched the dementia unit to determine if anyone was missing. Staff #1 did not find Tenant #1. Tenant #1 was found by a neighbor who contacted 911 and Tenant #1 was transported to the ER. Tenant #1 returned to the Program with facial and arm lacerations. Staff was re-trained regarding safeguarding tenants at risk of elopement.

- 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))