IOWA DEPARTMENT OF
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Complaint/Incident Intake #:
46747-I

February 20, 2014

Ms. Diane Giddings, Manager
Clover Ridge
205 Ehlers Lane
Maquoketa, IA 52060

RE: Final Complaint/Incident Investigation Report, Clover Ridge, Maquoketa, Iowa

Dear Ms. Giddings:

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 **February 3, 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:

Diane Giddings, Manager
Clover Ridge
205 Ehlers Lane
Maquoketa, IA 52060

Complaint/Incident Intake #: 46747-I

Date of Complaint/Incident Investigation:

February 3, 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:	21
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	21
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	9
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	42

Program History – The Program received regulatory insufficiencies in the area of Staffing during this certification period.

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; however, staff failed to investigate the cause of the alarm.

- Monitoring Observation: Tenant #1, a 72 year old, was admitted on 6-20-13 and diagnoses include: Dementia with Behavioral Disturbances, Hypertension with Lower Extremity Edema, Chronic Anxiety with Paranoia, Hypokalemia, Hyperlipidemia, Constipation, Benign Prostrate Hypertrophy and Pedal Edema. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the dementia specific unit.

  According to an Incident Report dated 12-27-14 (should be dated 2013) at 5:30 p.m., Tenant #1 was leaving memory care apartments for an outing with staff. Tenant #1 followed staff out of memory care, but when Tenant #1 looked up the group was gone. Tenant #1 exited the building through side door.

Tenant #1 was found by staff walking towards the activity van. Tenant #1 was brought back into the building and was dressed appropriately. Tenant #1 decided not to go on the outing, stated family was coming later and Tenant #1 would wait for family. There was no negative outcome. The nurse and family were notified.

According to the Nurse's Care Notes dated 12-27-13, a nurse review was completed for exiting the building. Tenant #1 was leaving memory care apartments for a planned outing with staff. Tenant #1 followed community staff and peers out the memory care door. Tenant #1 reported group got ahead of him/her and when he/she looked up the group was out of sight. Tenant #1 then turned and exited the building through a side door to get to the van. Tenant #1 was found by another staff member on Tenant #1's way to the activity van. Tenant #1 was wearing a winter coat and appropriate footwear. The temperature was 33 degrees and no wind chill. A full skin assessment was not required as Tenant #1 was dressed appropriately and only walked from the side exit to the front of the building. No negative outcome for Tenant #1.

The service plan was updated on 12-30-13 and indicated staff needed to be aware Tenant #1 may get confused and lose direction when leaving memory care. If Tenant #1 was confused, Tenant #1 may mistakenly exit or get lost inside the Program. Staff would be aware if Tenant #1 was leaving memory care for an activity or outing Tenant #1 would be accompanied by staff or family.

The Manager stated on 12-27-13 around 5:00 p.m., she was headed to her car and saw someone walking at the edge of the parking lot headed towards the van. It was Tenant #1 and she approached and asked if she could help. Tenant #1 stated he/she was going on the van ride but wanted to wait a minute. Tenant #1 sat on a bench by the front door of the building. Staff #1 was headed outside so the Manager had Staff #1 help Tenant #1 into the building. Tenant #1 changed mind and wanted to go into the building and call family instead of going on the van ride. The Manager checked the perimeter of the building where Tenant #1 had been outside. Tenant #1 was taken to memory care and was safe. Tenant #1 was wearing a winter coat and thick slippers. The temperature was 33 degrees and it was light outside due to the outside lights. She interviewed all staff involved and wrote up her investigation notes. When the alarm system was activated it showed on the Universal Workers' pagers. Staff #2 was in the apartment area and approached kitchen staff and the Maintenance Director to ask what the EXP-SW code meant. The Maintenance Director told her the general area where the alarm could be. Staff #2 reset the alarm. The Manager talked to Staff #2 later to ask what happened. In-services were held to review all policies and definitions. Tenants would always be with staff or family in the future.

Staff #1 stated she normally worked from 8:30 a.m. to 5:00 p.m. but stayed late to help load the bus. She was at her desk when she saw the Manager was on her way into the building with Tenant #1. She asked Tenant #1 if he/she was going on the van and Tenant #1 responded he/she was waiting for a ride. Tenant #1 returned to memory care and Staff #1 continued to help tenants get onto the bus and van while the Activity Coordinator went to get the tenants.

Staff #2 stated she was working up front that day and tenants were being escorted to the bus. She was in the memory care hallway when the Nurse and Activity Coordinator were getting tenants. She saw some tenants pass by and Tenant #1 was with the group.

She was paged to the west side of the building and then another page came for the southwest. She responded to the alarm but couldn't find the exit. She bumped into the Maintenance Director and asked him and he said it was the Extension. When she went that way Tenant #1 was already back in the building being escorted back to the memory care unit. She stated nothing like this had happened before. Tenant #1 had not gone out before, liked to sit in the common area and liked to watch television.

The Maintenance Director was helping load the minibus and a van and was outside. He saw Tenant #1 come out by the garage. He stated the Manager might have been there. Tenant #1 was fully dressed wearing a coat. Staff #2 asked him what door was alarming and he told her it was the new building, the SW Extension door but Tenant #1 was already in the building by that time. He stated he was going to drive the van, it was a nice night for a drive, no rain or snow and the temperature wasn't too bad.

The Nurse stated she was helping tenants into the van and was in the building when the Manager brought Tenant #1 into the building. The Manager said she saw Tenant #1 walking towards the van. The Nurse walked Tenant #1 back to memory care and Tenant #1 told her he/she thought his/her family might visit that night. Tenant #1 decided to stay instead of going on the van ride. Tenant #1 was wearing a winter jacket and tennis shoes. The temperature was in the 30 degrees, no wind, rain, ice or snow. She took Tenant #1's vitals. Tenant #1 told her he/she left with the group, he walked with his head down and had a slow gait. When he looked up the group was gone.

The Activity Coordinator stated she went to memory care to check on the tenants. A group of tenant's exited memory care to meet in the lobby before getting in the vehicles. She didn't recall if she saw Tenant #1 in the group. She had seen Tenant #1 earlier wearing his/her coat and sitting in a chair in the living room area. She heard the computer at the nurse's station in memory care indicate the SW door alarmed.

She asked Staff #3 to check that door but staff wasn't really sure where the SW door was located. The Activity Coordinator continued to help memory care tenants get ready; toileting and getting coats. She thought Tenant #1 was in a group that was led by a volunteer. She came out with some tenants and when she got to the front lobby heard that Tenant #1 had gone out the side door and the Manager brought him back into the building. Tenant #1 said he/she thought his/her family was coming; he was confused and did not go on the van ride. Tenant #1 was fully dressed, it was 28 degrees and one of the warmest nights, no rain or snow. She no longer allowed any tenant from memory care to leave without herself or another staff.

Staff #3 worked in memory care and knew Tenant #1 was going on a van ride. She told Tenant #1 not to forget his/her coat and got the coat out and placed it on Tenant #1's bed. The Activity Coordinator and the Nurse were helping tenants and she saw Tenant #1 waiting by the door but she didn't see Tenant #1 exit the area. She was clearing dishes when the door alarm sounded. When she was oriented, she was told to only respond to memory care alarms and the staff up front would take care of the other alarms. Tenant #1 didn't wander, was very content and never wandered off.

Staff #4 stated she was in memory care assisting with the tenants at meal time. Several tenants were standing outside the nurses' station in the hallway waiting to leave. She didn't see them leave and did not see Tenant #1. The pager alarmed and said "EXP-SW." She was the only one in memory care at the time and was trained if working in memory care and the alarm up front went off, she was not to leave.

According to an Alarm Response Report on 12-27-13 the door alarmed at the Expansion: EXP West South Exit at 16:58:31 and the alarm was cleared at 17:10:06 with a response time of 11:35 minutes.

According to the Elopement Policy, elopement was defined as a tenant with impaired decision making ability (GDS 4 or above) leaving the Program without supervision and posing a risk to self. If a tenant went out of the apartment an emergency call would be activated notifying staff to check on the tenant. The procedure indicated if any door alarm sounded, check alarms promptly. Thoroughly check inside and outside areas triggered by the alarm. The Staffing Policy indicated the Program would employ sufficient trained staff to be available to meet identified tenant needs. Staff was available 24 hours a day to respond to emergencies.

According to the Manager, the Nurse and Staff # 5 there was enough staff to meet the needs of the tenants.

A layout of the Program was obtained. The Manager indicated on the layout the location she observed Tenant #1, the location of the bus, the van and the route Tenant #1 walked towards the van and back into the building.

The monitor observed the area where Tenant #1 exited the building. The path taken was most likely approximately 15 feet of sidewalk, then walked on the yard behind the garage, turned at the garage corner and approached the parking lot where Tenant #1 was observed by the Manager.

The Manager provided a copy of the sign in sheet for a 1-2-14 mandatory staff in-service. The in-service covered alarms and staff expectations and changes regarding tenants leaving the memory care unit with only staff or family. Attached to the sign in sheet were the Elopement Policy and Assisted Living Definitions. A handout of identified exits was provided. The Manager stated new signs were placed at the memory care exits that stated only family or staff could escort tenants from the area. A copy of the sign was provided.

According to the State Climatologist, on 12-27-13 at 5:53 p.m. at the Dubuque airport, the temperature was 32 degrees, winds from the south at 13 miles per hour with a wind chill of 23 degrees under clear skies. On 12-27-13 at 5:52 p.m., at the Davenport airport, the temperature was 38 degrees, winds from the south at 14 miles per hour with a wind chill of 30 degrees under clear skies.

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

Per review of Tenant #1's file, Manager, Nurse and staff interviews and review of policies, Tenant #1 exited the building, the alarm functioned but staff did not know which door alarmed. The Manager observed Tenant #1 walking in the parking lot towards the van. Tenant #1 was dressed appropriately and did not sustain any injuries. Tenant #1 was assisted into the building and decided not to join the activity. The service plan was updated and staff was re-trained regarding responding to alarms.

- 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))