IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 46588-I

February 18, 2014

Ms. Mary Jo Pipkin, Executive Director
Keystone Cedars
6325 Rockwell Drive NE
Cedar Rapids, IA 52402

RE: Final Complaint/Incident Investigation Report – Keystone Cedars, Cedar Rapids, IA

Dear Ms. Pipkin:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of February 6 and 10, 2014, 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 515/281-7039 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 #:** 46588-I

Mary Jo Pipkin, Executive Director
Keystone Cedars
6325 Rockwell Drive NE
Cedar Rapids, IA 52402

Date of Complaint/Incident Investigation:

February 6 and 10, 2014

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:	63
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	64
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	7
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	79

Program History – During the Recertification visit of May 5, 2012, the program did not receive any regulatory insufficiencies. The program received regulatory insufficiencies in the areas of: Policy and Procedure, Program Reporting to the Department and Life Safety during the July 30, 2012, Complaint Investigation (40022-C). The program received regulatory insufficiencies in the areas of Tenant Rights and Staffing during the March 5, 2013, Complaint Investigation (42535-C). During the June 12 and 13, 2013, Complaint Investigation (43989-C), the program received regulatory insufficiencies in the areas of: Criteria for Admission and Retention, Evaluation, Service Plan, Tenant Rights and Nurse Review.

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

A. Tenant Documents

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

- Monitoring Observation: According to the ALP Monitoring Entrance Form, Tenant #1 eloped from the Program. There were no other elopements indicated on the form. Interviews with Staff #2, Staff #3, the Director of Nursing (DON) and the Executive Director (ED) indicated Tenant #1 eloped and no other tenants had eloped.

  Tenant #1, a 94 year old, was admitted on 3-5-12 and diagnoses included: Moderate Dementia, Osteoarthritis, Borderline Hypertension (HTN), Benign Prostatic Hypertrophy and Macular Degeneration. Tenant #1 was staged a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in the secured dementia unit.

Tenant #2, a 94 year old, was admitted on 3-5-12 and diagnoses included: Dementia (mild to moderate in advancing state with inability to care for self), Osteoporosis, Aortic Insufficiency, Osteoarthritis, Chronic Constipation, Allergic Rhinitis and HTN. Tenant #2 scored a 28/30 on the Mini Mental State Examination. Tenant #2 resided in the secured dementia unit.

Tenant #1 and Tenant #2 were spouses and lived in the general population at the time of the elopement. Tenant #1 and Tenant #2 moved to the secured dementia on 12-20-13, after the elopement. The general population section of the Program was not dementia specific by definition or dedication and door alarms were not required for the general population.

According to an Incident/Accident Report, on 12-16-13 at 3:49 p.m. Tenant #1 was found out front of the Program by Staff #1. Tenant #1 was not wearing a coat and was looking for Tenant #1's car. Tenant #1 was under no distress. Staff #1 escorted Tenant #1 back into the building. Tenant #1 was warm to touch but confused as to where Tenant #1's vehicle was located. Tenant #1 was taken back to Tenant #1's apartment to be with Tenant #1 spouse (Tenant #2). The DON took vitals. Tenant #1's skin was warm and dry. Tenant #1's vital signs were as follows: temperature 98.7, pulse rate 68, respiration rate 18, blood pressure 122/66 and oxygen saturation was 97% on room air. Tenant #1's gait was slow and steady. Tenant #1 ambulated independently with no assistive device. Tenant #1 was redirected to the apartment without difficulty. Signs were placed in the apartment reminding Tenant #1 that Tenant #1 did not have a car there and instructed Tenant #2 to utilize the call system anytime Tenant #1 left the apartment without Tenant #2. One hour safety checks were implemented. Tenant #1 was moving to the dementia care on 12-20-13.

According to Nurse's Notes dated 11-7-13, staff reported Tenant #1 had increased confusion. That morning Tenant #1 was exit seeking, looking for Tenant #1's car. Tenant #1 was confused most of the time, Tenant #2 usually provided orientation. Family noticed increased confusion in Tenant #1 and Tenant #2. The doctor was faxed. A urinalysis (UA) with culture and sensitivity if indicated would be collected. One hour safety checks were in place with day programming in the dementia unit until UA results were received.

According to Nurse's Notes dated 11-8-13, the UA was negative, staff was instructed if Tenant #1 was wandering or confused to initiate one hour rounds and assist Tenant #1 to the dementia unit for day programming. Family was possibly looking into placement in the dementia unit.

According to Nurse's Notes dated 12-9-13, nurse review, evaluations and service plan update were completed due to progressive confusion/dementia. A move to the dementia unit was anticipated with next availability.

According to Nurse's Notes dated 12-16-13, the DON was alerted by the ED that Tenant #1 was escorted inside by staff. Tenant #1 was alert and oriented to self and significant others. Tenant #1's skin was warm and dry and vital signs were taken. Tenant #1's gait was slow and steady without an assistive device. Tenant #1 was looking for Tenant's #1 car and it was explained there were no garages so Tenant #1's family member had the car. Tenant #1 was accepting of that. Tenant #1 was

directed to the apartment with staff. Signs were placed in the prominent locations in the apartment reminding Tenant #1 that Tenant #1 did not have a car there and instructed Tenant #2 to call for staff if Tenant #1 left without Tenant #2. Staff was directed to complete one hour visual checks. Family was notified. Tenant #1 and Tenant #2 were set to move to the dementia unit on 12-20-13. Family would come that evening and starting on 12-17-13 staff would take Tenant #1 to the dementia unit at 3:00 p.m. until supper in the assisted living dining then staff would escort to the apartment and bed. Tenant #1 did not leave the apartment after supper once Tenant #1 was in the apartment.

Nurse's Notes dated 12-20-13 indicated all belongings were moved to an apartment in the dementia unit.

The service plan dated 12-9-13 indicated Tenant #1 often got lost going place to place and was redirected easily. The service plan indicated if Tenant #1 was wandering increase two hour rounds to one hour rounds. Tenant #1 was very hard of hearing, to make sure hearing aids were in and working. Tenant #1 could be taken to the dementia unit with increased wandering as needed. The service plan was updated on 12-16-13 at 4:00 p.m. to reflect one hour rounds day and night and to take Tenant #1 to the dementia unit at 3:00 p.m. until supper then escort to the apartment.

Review of documentation for Tenant #1's checks indicated checks or rounds were not consistently documented completed including the following: on 12-16-13 checks were completed at 7:00 a.m., 9:00 a.m., 11:30 a.m., 1:30 p.m. and then hourly checks started at 4:00 p.m. after the elopement. A check was not documented for Tenant #1 from 1:30 p.m. to 4:00 p.m. At 1:30 p.m. Tenant #1 was in the room. At 4:00 p.m. it was documented Tenant #1 was wandering. The checks for Tenant #2 indicated staff documented a check for Tenant #2 on 12-16-13 at 3:00 p.m. and it was noted Tenant #2 was watching television. Checks were to be completed on an hourly basis day and night for Tenant #1 which was implemented at 4:00 p.m. on 12-16-13. Checks were documented hourly from 4:00 p.m. to 10:00 p.m. The last check documented on 12-16-13 was at 10:00 p.m. and there were no documented checks until 6:00 a.m. on 12-17-13. There were checks completed as documented for Tenant #2 on an hourly basis from 10:00 p.m. on 12-16-13 until 5:00 a.m. on 12-17-13. Tenant #1 and Tenant #2 shared an apartment at the time the checks were completed.

Staff #1 said she had been at the independent living building that afternoon and was crossing the street to come back to the Program. Staff #1 estimated it was approximately 3:00 p.m. to 3:30 p.m. as it was usually the time she came back to the Program. Staff #1 was headed west crossing the street. Tenant #1 was headed northwest on a sidewalk. Staff #1 said it seemed like Tenant #1 would have almost been even with the front of the building but it might not been that far. Staff #1 recognized Tenant #1 right away and assumed Tenant #1 might have been looking for Tenant #2. Staff #1 started calling Tenant #1's name; however, Tenant #1 was hard of hearing. There was a person getting into a car and the person could see Staff #1 was trying to catch up to Tenant #1. The person got Tenant #1's attention, enough that Staff #1 could catch up to Tenant #1. The person was parked along the street. Once Staff #1 caught up to Tenant #1, Staff #1 said Tenant #2 was inside. Tenant #1 said Tenant #1 was looking for Tenant #1's car. Staff #1 redirected Tenant #1 back into the building. Tenant #1 ambulated independently. Tenant #1 was not wearing a

coat; however, Tenant #1's arms were covered either by a long sleeved shirt or sweater. Staff #1 said she did not get the feeling Tenant #1 was cold. Tenant #1 was intent on finding Tenant #1's car. Staff #1 tried to reconstruct where Tenant #1 would have come out and she said possibly on the main floor south door that came out into the back parking lot. When Staff #1 saw Tenant #1, he/she had rounded the corner and was headed northwest. Once back in the building Staff #1 told someone she had found Tenant #1 outside. The ED and DON were there soon after. Staff #1 said she sensed right away that Tenant #1 was not outside very long and there were no signs of Tenant #1 being cold. Tenant #1 did not sustain any injuries. Staff #1 said Tenant #1 and Tenant #2 were always together and relied a lot on each other.

Staff #2 said there was enough staff to meet the needs of the tenants. There were no tenants that exceeded the level of care. Staff #2 did not identify any other tenants besides Tenant #1 who had eloped. Staff #2 worked first shift on the day the elopement occurred. On the day of the elopement, Tenant #1 and Tenant #2 were headed back to the room in the hallway at 1:00 p.m. Shortly after 1:00 p.m. Staff #2 went to the apartment and checked on them. Tenant #1 and Tenant #2 were both in recliners. That was the last scheduled check for Staff #2 to complete on her shift. Staff #2 was not in the building when the elopement occurred. On the day of the elopement Tenant #1 was not exit seeking or wandering. There was nothing unusual with Tenant #1 on that day. Tenant #1 did not receive any assistance with activities of daily living in the afternoon. Staff #2 said Tenant #1 was doing well in the dementia unit and there had been no issues with elopement or exit seeking. Tenant #1 ambulated independently without an assistive device. Checks were completed appropriately. There had been no previous elopement attempts with Tenant #1.

Staff #3 said there was enough staff to meet the needs of the tenants and there were no tenants that exceeded the level of care. Staff #3 did not identify any other tenants besides Tenant #1 who had eloped. Staff #3 worked second shift on the day of elopement. Staff #3 said at 3:00 p.m. Tenant #1 was on the couch in the apartment. Staff #3 said Tenant #1 did not have a history of elopements. Tenant #1 ambulated independently. Staff #3 said Tenant #1 was doing a lot better in the dementia unit. Tenant #1 had not been exit seeking or attempting to leave since the move to the dementia unit.

The DON said there was enough staff to meet the needs of the tenants and there were no tenants that exceeded the level of care. The DON did not identify any other tenants besides Tenant #1 who had eloped. The DON said she was at the nurse's station and the ED had the DON come to the front lobby. The ED explained Staff #1 had brought Tenant #1 in the building. The DON completed an assessment. There were no issues with Tenant #1's skin and it was warm. Vital signs were taken and there were no issues. Tenant #1 was wearing a long sleeved shirt, pants, a t-shirt, socks and shoes. Tenant #1 was not wearing a coat. Tenant #1 ambulated independently without an assistive device. After the assessment, the family was notified and the rest of the assessment was completed in Tenant #1's apartment. A sign was put in Tenant #1's apartment regarding the car was not there and Tenant #2 was to notify staff if Tenant #1 left without Tenant #2. A family member stayed that night until Tenant #1 went to bed. The DON checked on Tenant #1 before she left. Hourly visual checks were completed until the move to the dementia unit. The weather was cold and the DON was surprised Tenant #1's skin was as warm as it

was. Tenant #1 did not sustain any injuries. Tenant #1 did not have any history of elopement or exit seeking and had no subsequent elopements.

The ED said there was enough staff to meet the needs of the tenants and there were no tenants that exceeded the level of care. The ED did not identify any other tenants besides Tenant #1 who had eloped. There was no history of elopements or subsequent elopements with Tenant #1. Staff #1 had brought Tenant #1 inside the building. Staff #1 came from across the street and caught up to Tenant #1 from the backside and there was another person leaving the Program that came from the other side. Staff #1 talked to Tenant #1 and brought Tenant #1 back in the building. The ED felt Tenant #1's hands right away and they were room temperature and were not cold. The DON completed an assessment and vital signs were taken and there was nothing abnormal. Tenant #1 did not sustain any injuries. The ED said the incident was handled well. It was a usual day and there was nothing out of the ordinary regarding Tenant #1. Tenant #1 was wearing slacks, a shirt, a t-shirt, socks and shoes. Tenant #1 ambulated independently. There had been no attempts or elopements for Tenant #1 since Tenant #1's move to the dementia unit.

Tenant #1 was not observed leaving the building and the point of exit was not witnessed; however, Staff #1 observed Tenant #1 on a sidewalk heading northwest.

According to the State Climatologist, on 12-16-13 at 3:47 p.m. at the Cedar Rapids Airport the conditions were as follows: temperature 18 degrees, winds from the west at 5 miles per hour, a wind chill of 11 degrees and cloudy skies with no precipitation.

According to documentation of Tenant #1's checks, the checks were not consistently documented as completed per the frequency indicated on the service plan. While a deviation from 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.