IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 47134-I

April 2, 2014

Ms. Inde Miller, Executive Director
Vriendschap Village AL
2604 Fifield Road
Pella, IA 50219

RE: Final Complaint/Incident Investigation Report – Vriendschap Village AL, Pella, IA

Dear Ms. Miller:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 25 & 26, 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 #: 47134-I

Inde Miller, Executive Director
Vriendschap Village AL
2604 Fifield Road
Pella, IA 50219

Date of Complaint/Incident Investigation:

March 25 & 26, 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:	32
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	35
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	5
TOTAL census of Assisted Living Program	40

Program History – During the Recertification on-site of 11/29/12, the program did not receive any regulatory insufficiencies. During the 1/16/13 Incident Investigation (42128-I) the program did not receive any regulatory insufficiencies. During the 5/1/13 Complaint Investigation (43437-C), the program received regulatory insufficiencies in the areas of: nurse review, evaluation, service plan and tenant documents. During the Incident Investigation (46196-I) of 11/19/13, the program did not receive any regulatory insufficiencies.

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 the alarm did not sound when Tenant #1 exited the dementia unit.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 8-8-13 and diagnoses include: Alzheimer's Dementia, Hypothyroidism and Benign Prostrate Hypertrophy. Tenant #1 was staged at a six on the Global Deterioration Scale which indicated severe cognitive decline. Tenant #1 resided in the dementia unit.

  According to a service plan dated 12-9-13, Tenant #1 needed assistance with bathing, reminders for grooming tasks, assistance with dressing and undressing, reminders to attend meals, escort to and from meals and events, observation for fall risk, medication administration and redirect as needed so Tenant #1 didn't wander into other tenant rooms.

  According to a Resident Incident Report dated 2-5-14 at 5:50 p.m., Tenant #1 walked out the back door and exited the door to the outside, walked around the building to the assisted living dining room door where Tenant #1 was found pounding on the

door. The back door alarm was unalarmed so it wasn't working. Vital signs were Temperature 98 degrees, Pulse 90, Respiration 12 and Blood Pressure 129/70. Follow up action to be taken included checking on Tenant #1 and door alarms every half hour starting on 2-5-14 and lasting until further notice.
Staff #1 was interviewed and stated she was working in the dementia unit and had checked the alarms around 1:30 p.m. and they were working. After supper she was cleaning off the tables when Staff #2 came in with Tenant #1 and said Tenant #1 had gotten out. She checked the alarms again and the front door was working but the back door was not. You could open the door and no alarm sounded and there were no blinking lights. She flipped the breaker and flipped the switch but it still didn't work. Staff #2 called the RN Coordinator who called the Executive Director (ED). The Maintenance person arrived, took the key to the alarm door and tried turning it and then the alarm started working after the second try with the key. Staff #1 stated dinner was served at 5:00 p.m. and Tenant #1 was at dinner and left the dining room around 5:30 p.m. She stated she never heard any alarms. Tenant #1 was wearing a long sleeved shirt, long pants, socks and shoes. Tenant #1 was not wearing a coat. She said it was very cold outside. After Tenant #1 returned she looked out the back door and could see Tenant #1's footsteps in the snow.

Staff #2 was interviewed and stated she was in the AL dining room serving meals. One of the tenants said there was someone outside. The tenant opened the door and let Tenant #1 inside. Staff #2 held Tenant #1 and rubbed arms to warm up Tenant #1. She called the RN Coordinator around 5:35 p.m. or 5:36 p.m. according to phone records. She went out the dining room to track Tenant #1's steps in the snow stating Tenant #1 walked from the exit door, along the building to the walking path that led to the dining room door. She stated Tenant #1 walked with a very slow pace and she accompanied Tenant #1 back to the dementia unit. As they walked to the dementia unit, Tenant #1's family arrived, was told what happened and walked with them. Tenant #1 was wearing a long sleeved shirt, long pants, socks, shoes and was not wearing a coat. She stated it was pretty cold that night.

The Maintenance person was interviewed and stated staff called him at home and said the alarm was beeping. He had been there before to put in a new fuse. He arrived and tried the switch in the wall to reset the system, he checked the fuse and it was okay. He turned the breaker off and on, put the key in the door and turned it and the lock worked. The light was blinking like it should and everything was fine at that point.

The RN Coordinator stated she received a call at home on 2-5-14 at 5:30 p.m. and staff said Tenant #1 had gotten outside and was seen through the AL dining room window. Tenant #1 knocked on the window and staff ran out to assist. She called the ED who came into the building and Tenant #1's family was there. The next morning she completed an assessment and notified Tenant #1's physician. She stated there had not been any further elopement attempts since this incident. Tenant #1 goes to the door and it alarms and Tenant #1 is easily redirected. She stated there had not been any previous issues with the alarms not working. She had dressed Tenant #1 that morning in a long sleeve shirt, long pants, socks and shoes. She went outside to retrace the path taken and saw footprints in the snow. Tenant #1 walked along the edge of the building.

The ED stated around 5:40 p.m. she received a call from the RN Coordinator who said Tenant #1 had gotten outside. She immediately returned to the building and arrived about 30 minutes later. She talked to Staff #1 and Staff #2 to find out what had happened. She spoke with Tenant #1's family. The Maintenance person had already come and gone by the time she arrived and the alarms were working when she got to the Program. She determined the door had latched before it closed and that was the reason the door would not have alarmed. She called the alarm company the next morning and had them check the doors. Tenant #1 was checked every half hour and the doors were checked every half hour as well. The alarm company came out and accidently fried the board but a new one was there within one hour. The way the alarm was set up previously required you use a key to turn off the alarm. When the alarm company was there they set it so the door would alarm if the door did not latch, didn't shut or if someone held the door open. Additionally a chirp alarm was installed and a Velcro stop sign was placed in front of the door.

The staff checked Tenant #1's vital signs, completed a skin check and wrapped Tenant #1 in blankets. Tenant #1's family arrived at the time Tenant #1 was walked back to the dementia unit. The ED was told Tenant #1 was at supper in the dementia unit dining room, ate and then left. The meal started around 5:00 p.m. An AL dining room tenant said there was a man in the courtyard and at first Staff #2 thought it could be a meter reader. When she saw it was Tenant #1 she brought Tenant #1 inside. The next morning she and the Maintenance person used a tape measure and followed Tenant #1's footprints to measure the distance walked and it was 200 feet. Tenant #1 shuffled when Tenant #1 walked so she had no idea how long it would have taken Tenant #1 to walk around the building. There were footprints in the snow and Tenant #1 would have walked on grass until reaching a sidewalk area. The sidewalk was cleared but there was still some snow so she could see the path walked. Tenant #1 took the sidewalk to the dining room doors and Staff #2 said Tenant #1 was knocking on the dining room door window. Tenant #1 did not have any injuries, was completely dry and would have been wet if Tenant #1 had fallen. Tenant #1 was wearing a long sleeved shirt, long pants, socks and shoes. Tenant #1 was not wearing a coat. She thought it was about six or eight degrees outside at the time of the incident and it was not snowing.

According to Progress Notes dated 2-6-14 at 8:20 a.m., the Nurse Coordinator assessed Tenant #1 after Tenant #1 went outside the previous night. Skin was pink and warm, no dryness or blotching on fingers, nose, face or toes. Nothing indicated Tenant #1 had any sign or symptoms of hypothermia or frost bite. Tenant #1 was moving about as usual and denied pain when asked. Safety measures remained in place at the time included checking the door and checking on Tenant #1 every half hour.

Functional, cognitive and health evaluations were completed on 2-6-14. According to the service plan dated 2-6-14, Tenant #1 had exit seeking behaviors and staff were to redirect with the use of offering coffee, listening to music, playing card games, reading and a country magazine. Tenant #1 would be observed every 30 minutes for safety checks and visualization.

According to an Elopement Policy on Alarm Checks, the Program Director should ensure there is a process for door alarms to be checked daily. The ED stated the

process prior to the elopement and ongoing was to check alarms one time each shift. Door Alarm Logs were provided from 1-11-14 through 2-5-14 which indicated the date and time of the door alarm checks, if the door was secured or not secured and the initials of the staff member that completed the checks. Thirty minute visual checks for Tenant #1 and door alarm checks from 2-5-14 through 2-11-14 were provided.

The ED stated the Program had an elopement drill on 12-25-13 and also had a in-service on elopement procedures after the incident. Staff was now on a heightened awareness and made sure no tenants followed them out the doors. The ED provided copies of invoices for the alarm service visits and the order for the Velcro stop sign.

Staff #1, #3, the RN Coordinator and the ED stated there was enough staff to meet the needs of the tenants.

A layout of the Program was obtained. Tenant #1's apartment was located across from the community room and was the apartment furthest away from the exit door taken to leave the dementia unit. The monitor observed the dementia unit exit door at the end of the east hallway which led into a stairwell, approximately 30 feet from the exit door that led outside.

According to the State Climatologist, on 2-5-14 at 5:35 p.m. at the Pella Regional Airport, it was 5 degrees with winds from the NW at 10 miles per hour, wind chill of minus 10 degrees and clear skies.

An incident report was completed and the Department was notified.

- Regulatory Insufficiency: None noted.