IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47830-C

July 7, 2014

Mr. Travis Senters, Community Director
Ridgeview Assisted Living
2975 F Avenue NW
Cedar Rapids, IA 52405

RE: Final Complaint/Incident Investigation Report – Ridgeview Assisted Living, Cedar Rapids, IA

Dear Mr. Senters:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of June 18 & 19, 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 #:** 47830-C

Travis Senters, Community Director
Ridgeview Assisted Living
2975 F Avenue NW
Cedar Rapids, IA 52405

Date of Complaint/Incident Investigation:

June 18 and 19, 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:	39
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	39
TOTAL census of Assisted Living Program	39

Program History – During the Recertification on-site of January 28, 2013, 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. Evaluation

Complaint/Incident Allegation: It was alleged a tenant eloped.

- Monitoring Observation: The ALP Monitoring Entrance Form indicated there were no elopements and there were no tenants that wandered throughout the Program. Five tenant files including current and discharged tenants were reviewed (Tenants #1, #2, #3, #4 and #5). According to a review of Tenant #1's file and an incident report Tenant #1 was found outside the building on 2-5-14.

  Tenant #1, a 66 year old, was admitted on 12-14-13 and diagnoses included: Peripheral Vascular Disease, Diabetes Mellitus Type II, End Stage Renal Disease, Kidney Transplant (2010), Hyperlipidemia, Obstructive Sleep Apnea, Cerebrovascular Accident, Depression, Anemia, Macular Degeneration, Hearing Loss and Hypertension. Tenant #1 was staged at a two on the Global Deterioration Scale (GDS), which indicated very mild cognitive decline on 12-17-13, 1-9-14 and 1-16-14. Tenant #1 was staged at a four on the GDS, which indicated moderate cognitive decline on 1-31-14. Tenant #1 was discharged on 2-14-14.

  According to an incident report, on 1-31-14 at 11:00 a.m. Tenant #1 was observed lying on left side on the hallway floor. Staff was walking Tenant #1 to exercise class and Tenant #1 continuously stopped and asked staff why staff was following Tenant #1. Then Tenant #1 stopped walking and kneeled to the ground on Tenant #1's knees. Staff assisted Tenant #1 to a lying position. While a nurse was assessing Tenant #1, Tenant #1 refused to talk by verbalizing Tenant #1 could not talk. The nurse said Tenant #1 was talking so Tenant #1 then verbalized only Tenant #1's knees hurt. There were no injuries noted.

According to a Witness Statement the tenant involved was Tenant #1, the location was Tenant #1's apartment, the date and time of incident was 1-31-14 at 11:00 a.m. Tenant #1 pressed the pendant and staff responded. Tenant #1 did not know what Tenant #1 wanted but Tenant #1 needed help. Staff asked several times how staff could help Tenant #1 and Tenant #1 continued to say Tenant #1 did not know but felt trapped in Tenant #1's apartment. Staff replied that they were not trapped and could leave if Tenant #1 wanted. Staff asked Tenant #1 what was wrong and Tenant #1 continued to say Tenant #1 needed help killing himself/herself. Staff asked if Tenant #1 needed the nurse for medications and Tenant #1 replied only if the nurse could help kill Tenant #1. Staff replied they would not help Tenant #1 with that. Tenant #1 got upset and got physically closer to staff and said again Tenant #1 needed help to kill himself/herself. Staff backed up as to avoid getting hit by Tenant #1. Staff offered to take Tenant #1 to exercise class and Tenant #1 said yes.

Nurse's Notes dated 1-31-14 indicated a significant change (evaluation) was completed for behaviors and the service plan was updated.

Tenant #1 was staged at a two on the GDS, which indicated very mild cognitive decline on 12-17-13, 1-9-14 and 1-16-14. Cognitive, health and functional evaluations were completed and the service plan was updated on 1-31-14. Tenant #1 was staged at a four on the GDS, which indicated moderate cognitive decline on 1-31-14.

Tenant #1's durable power of attorney for health care was enacted by a physician on 1-9-14.

According to an incident report, on 2-5-14 at 8:40 a.m. a staff was with Tenant #1 while a nurse called an ambulance. Tenant #1 was confused and not himself/herself that morning. Tenant #1 scooted forward in the recliner and slid out onto the floor. Tenant #1 did not complain of pain or discomfort and did not hit Tenant #1's head. Tenant #1 was assisted up to the wheelchair. The ambulance arrived at 8:45 a.m.

According to Nurse's Notes dated 2-5-14 at 9:00 a.m. staff asked what Tenant #1's blood sugar was because Tenant #1 seemed more confused and was unable to follow directions. Tenant #1 would not sit still in the chair and would try to scoot forward to where Tenant #1 would almost slip out. Tenant #1 was unable to follow cues and would not sit still. Staff tried to get Tenant #1 to eat but Tenant #1 did not understand what staff was telling Tenant #1. A wheelchair was used to get Tenant #1 back to the room. Staff stayed with Tenant #1 while an ambulance was called. Tenant #1 slid out of the chair on the floor. No injuries were noted. An ambulance arrived and Tenant #1 was out of the Program by 8:50 a.m. On 2-5-14 at 12:30 p.m. Tenant #1 returned from the hospital with a diagnosis of temporary loss of blood to the brain. Tenant #1 was very tired at that time.

According to an incident report, on 2-5-14 at 1:30 p.m. Tenant #1 was seen sitting on the floor leaning against the apartment door. Tenant #1 complained of hitting Tenant #1's head on the way down. There were three small red areas to the right side of the head. Tenant #1 then proceeded to roll around in the hall and crawl inside the room. Tenant #1 then rolled around the apartment and got into bed. Tenant #1 was covered

and resting as staff left the apartment. Tenant #1 refused vitals. Staff left the apartment at 1:40 p.m.

According to Nurse's Notes on 2-5-14 at 1:30 p.m. Tenant #1 was found on the floor in the doorway and staff tried to have Tenant #1 stand and Tenant #1 refused. Staff finally got Tenant #1 to stand up and Tenant #1 walked with assistance to bed. Tenant #1 reluctantly used the walker and was very unsteady on Tenant #1's feet. Tenant #1 also told staff Tenant #1 had to listen to the master but would not tell who it was or what it told Tenant #1. Tenant #1 did hit the right side of Tenant #1's head. Three red areas were noted. Tenant #1 was lying in bed.

According to an incident report, on 2-5-14 at 1:45 p.m. a call was received from Staff #1 (Maintenance) that Staff #1 was bringing Tenant #1 in from outside. The Director of Nursing (DON) met Staff #1 and Tenant #1 in the hallway. Tenant #1 leaned up against the wall and slid down the wall to sit. Tenant #1's feet were wet as Tenant #1 did not have shoes, socks or a coat on. Tenant #1's feet were cold but warmed up fast. Tenant #1 was upset and would not allow vitals to be taken. Tenant #1's family was notified and asked that Tenant #1 be sent back to the hospital.

According to a Witness Statement completed by Staff #1, the tenant involved was Tenant #1 and the date and time of the incident was 2-5-14 at 1:50 p.m. According to the statement approximately 10 minutes before 2:00 p.m. Staff #1 was shoveling outside the southwest entrance. Staff #1 then walked north to the "Tread Mill" door and noticed Tenant #1 was standing against the exterior of the building by the door. Staff #1 visited with Tenant #1 and said they had to go inside. Tenant #1 walked away from the building while holding Tenant #1's walker. Staff #1 said again that they had to go in and Staff #1 unlocked the door and held it open. Tenant #1 turned toward Staff #1 and they walked inside together. Staff #1 noticed Tenant #1 was not wearing a coat, shoes or socks. Staff #1 called the Program's phone number and gave them the location.

According to Nurse's Notes on 2-5-14 at 1:45 p.m. a call from received from maintenance staff that Tenant #1 was outside a side door. Maintenance staff brought Tenant #1 inside. Tenant #1 had no coat, shoes or socks on. Tenant #1 came up the hallway towards the nurse's station. Tenant #1 turned towards Tenant #1's apartment as the nurses approached Tenant #1. Tenant #1 proceeded to sit on the floor in the hallway. Tenant #1's family was notified and said to call an ambulance and send Tenant #1 back to the hospital. A second nurse stayed with Tenant #1. Staff assisted Tenant #1 off the floor and into a chair. The ambulance arrived and Tenant #1 was taken out of the Program by 2:00 p.m.

According to Nurse's Notes on 2-5-14 at 8:15 p.m. Tenant #1 was admitted to the hospital. According to Nurse's Notes dated 2-11-14 an email was received from Tenant #1's family and they believed Tenant #1 was going to need a secured facility. On 2-14-14 Nurse's Notes indicated Tenant #1's family moved everything out last night and dropped off the keys that morning.

Nurse's Notes dated 2-17-14 a late entry for 2-3-14 indicated Tenant #1's attitude and cognition were improved from 1-31-14. Tenant #1 was back to Tenant #1's baseline and would have been a GDS of two as of 2-3-14. Tenant #1's family visited with

Tenant #1 on 1-31-14 to 2-2-14 about Tenant #1's attitude. All staff that worked with Tenant #1 on 2-2-14, 2-3-14 and 2-4-14 said how much better Tenant #1 was. Tenant #1 answered questions correctly and was very cooperative with staff.

Staff #2, #3 and #4 did not identify any tenants that eloped or any tenants that exceeded the level of care. Staff #2, #3 and #4 said there was enough staff to meet the needs of the tenants. The DON and Community Director did not identify any tenants that exceeded the level of care. The DON and Community Director indicated there was enough staff to meet the needs of the tenants.

Staff#1 said he usually cleared sidewalks in the early morning and had shoveled the southwest entrance and came around the corner a saw Tenant #1 standing by the door up by the wall. Staff #1 noticed Tenant #1 did not have a coat or shoes on. Tenant #1 was standing by the building in the corner. Staff #1 opened the door and got Tenant #1 inside. Staff #1 said he could not remember if he called staff or saw them in the hallway. Staff #1 said the door was locked from the outside but was not alarmed. Tenant #1 did not have any injuries.

Staff #2 said Tenant #1 exhibited swallowing problems and went to the hospital. Tenant #1 returned from the hospital and Staff #2 helped Tenant #1 get settled. Staff #2 said 5 to 10 minutes from when staff left the apartment Tenant #1 went out the side door by Tenant #1's apartment. Staff #2 said Staff #1 found Tenant #1 outside. Tenant #1 was brought inside, Staff #1 stayed with Tenant #1 and called for help. Tenant #1 did not have any injuries. Staff #2 said Tenant #1 seemed to be okay but tired and did not voice concerns regarding leaving the building in the 5 to 10 minutes prior. Tenant #1 had not gone outside before by himself/herself.

The DON said on 2-5-14 Tenant #1 was out at breakfast and staff noticed Tenant #1 had trouble swallowing and Tenant #1 slid out of the chair. An ambulance was called and Tenant #1 went to the hospital. Tenant #1 returned with family and Tenant #1 was taken back to Tenant #1's apartment. Tenant #1 was in a recliner in the apartment. At approximately 1:30 p.m. staff was walking by and Tenant #1 was sitting by the doorframe. Staff got Tenant #1 up and laid Tenant #1 down in the chair. Staff left Tenant #1's apartment at approximately 1:40 p.m. At approximately 1:45 p.m. the DON received a telephone call from Staff #1 who said Tenant #1 was outside and he was bringing Tenant #1 back. The DON met Staff #1 and Tenant #1 in the hallway. Tenant #1 leaned against the wall and sat down. Tenant #1 was wearing pants and a shirt and was not wearing socks, shoes, a coat or a hat. The oncoming nurse stayed with Tenant #1 while the DON called Tenant #1's family and family said to send Tenant #1 back to the hospital. Tenant #1's feet were a little cold but were pink. Tenant #1 did not complain of being cold and there were no injuries observed. There was no indication of frost bite. The door was not an alarmed door but did require a key to get back in. Tenant #1 did not use the pendant and refused vitals. An ambulance came and took Tenant #1 to a hospital and Tenant #1 was admitted to the hospital. Tenant #1's family sent an email which indicated they were looking for different placement. The DON said Tenant #1 was able to make Tenant #1's own decisions and prior to the incident was able to tell staff Tenant #1 wanted to go to bed. Tenant #1 answered questions appropriately.

The Community Director said he was notified when Tenant #1 was brought back inside. Staff #1 had found Tenant #1 outside. Tenant #1 had a fall at 1:30 p.m. and was found outside at 1:45 p.m. He said the DON estimated Tenant #1 was outside for not more than five minutes. Tenant #1 was not wearing a coat or shoes. Tenant #1 did not have any injuries.

According to the State Climatologist at the Cedar Rapids Airport on 2-5-14 at 1:52 p.m. the temperature was 7 degrees, the wind chill was -12 degrees, the wind was from the northwest at 18 miles per hour and there was light snow.

The Program was a general population Program and was not required to have door alarms.

The incident with Tenant #1 on 2-5-14 at 1:45 p.m. when Tenant #1 was found outside the building was not required to be reported to the Department. Nurse's Notes dated 2-17-14 a late entry for 2-3-14 indicated Tenant #1's attitude and cognition were improved from 1-31-14. Tenant #1 was back to Tenant #1's baseline and Tenant #1 would have been a GDS of two as of 2-3-14. Although an entry in the Nurse's Notes indicated Tenant #1 returned to baseline and would have been a GDS of two as of 2-3-14, evaluations including the cognitive evaluation were not completed to reflect the change. 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.