IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 42975-I

April 18, 2013

Mr. Bruce Boehm, Manager
Sunnybrook Assisted Living of Carroll
1214 East 18th Street
Carroll, IA 51401

RE: Final Complaint/Incident Investigation Report, Sunnybrook Assisted Living of Carroll, Carroll, Iowa

Dear Mr. Boehm:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

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:

Bruce Boehm, Manager
Sunnybrook Assisted Living of Carroll
1214 East 18th St.
Carroll, Iowa 51401

Complaint/Incident Intake #:

42975-I

Date of Complaint/Incident Investigation:

March 18, 19 and 21, 2013

Monitor(s):

Maribeth Freland RN

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:	35
Number of tenants with cognitive disorder:	0
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:	12
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	47

Program History – There were regulatory insufficiencies in the area of Service Plans during this recertification period.

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 a staff member disengaged the alarms to egress doors located in the secured memory care unit and leading to an enclosed courtyard. A gait exiting from the courtyard was unlocked, leading to the elopement of one tenant who was in the courtyard unattended.

- Monitoring Observation: According to the program's policy, titled Exit Doors/Door Alarms and dated as revised in May 2011, all doors exiting from the Gardens (the program's secured memory care unit) shall be locked with alarm on at all times.

  According to the program's policy, titled Mandatory Safety on Memory Care Gardens and dated as revised in May 2011, the secured memory unit will have locked doors which are opened with a security code. Each door will also have a 15 second delay for egress.

  The program's secured memory care unit (The Gardens) had four exit doors, three exiting into an enclosed courtyard and one exiting into the general population area of the building. All four doors were secured, preventing unauthorized exiting from the unit. Each door had a keypad that could be used by staff members to bypass the secure system by putting in a common code. Each door had a 15 second egress bar.

When the egress bar was pushed, an alarm sounded notifying staff members of a potential unauthorized exit from the unit. With continuous pressure on the bar for 15 seconds the alarm continued to sound and the door would release allowing exit through the door. Each of the courtyard exit door egress/alarm systems could be deactivated by staff members with the use of a key. The key was carried by the medication passer on a key ring. When the alarm was activated, a red light indicator was present at the top of the door, signifying a secure system. When the alarm was deactivated, a green light indicator was present at the top of the door, signifying unsecured access to the courtyard.

During interview, Staff #2 and Staff #3, universal workers, both reported they each had deactivated the egress/alarm system multiple times by shutting off the system by key at each courtyard door due to repeated tenant attempts to go out the doors, sounding the alarms. Both universal workers reported Staff #4, the previous Gardens Coordinator, had often deactivated the courtyard doors in the same manner on nice days to allow open access to the courtyard by tenants residing in the unit and when tenants were repeatedly pushing on the egress bars, sounding the alarm system. Both reported cognitively impaired tenants were allowed to go into the courtyard unsupervised by staff members when the door alarm system was deactivated. Both reported they would keep watch over the tenants from inside the building when tenants were in the courtyard area.

The 150 foot wide by 90 feet deep secured memory care unit courtyard was enclosed by a five foot high fence. The building contained three exit doors leading into the courtyard, one entering into the middle of the courtyard and one at each end of the building. The fence had two gates, one at each end of the building. The gates exited into an open unsecured outside area.

During interview, Staff #2 and Staff #3 both reported the courtyard gates were to be locked at all times. Neither had ever checked the gates to assure the gates were secured prior to allowing cognitively impaired tenants to be in the courtyard area unsupervised.

During interview, the program Manager reported both Garden courtyard gates had been secured with a keyed lock that was attached to each gate. On 3-9-13 the locks on the gates were replaced with temporary locks due to lock failure. On 3-11-13 the Manager was informed by Sunnybrook Management that the gates should only be latched not locked. The Manager reported the temporary locks were removed completely on 3-11-13 and a new double latch system was placed on each gate with no lock. On 3-18-13 at approximately 2:15 p.m. neither gate was secured.

During interview, the program Maintenance Coordinator reported the Garden courtyard gates had previously been locked with a keyed lock attached to each gate. The Maintenance Coordinator reported the door locks were removed on 3-11-13.

The program reported two tenants, Tenant #1 and Tenant #2, wandered throughout the secured memory care unit. Tenant #2 often repeatedly pushed on the egress bars of the doors exiting into the enclosed courtyard.

Tenant #1 exhibited exit seeking behaviors and repeatedly pushed on the egress bars of the doors exiting into the enclosed courtyard, often times pushing on the bar for 15 seconds, releasing the lock and allowing exit from the building.

On 3-9-13, Staff #2 and Staff #3 worked in the Gardens. Staff #3 deactivated the egress/alarm system to the three doors exiting from the Gardens into the enclosed courtyard. The southwest gate lock was not locking properly, leaving the gate unlocked on 3-9-13. Tenant #1 exited through the southwest exit door twice during the morning. Tenant #1 exited through the unsecured gate at approximately 10:45 a.m. Tenant #1 was gone from the program without staff knowledge of his/her whereabouts for approximately 45 minutes.

Staff #2 and Staff #3 admitted to deactivating the egress/alarm system from the courtyard doors in the memory care unit. Staff #2 and Staff #3 both denied ever checking the gates in the courtyard to assure each was secure before deactivating the alarms. Staff #2 and Staff #3 admitted to allowing cognitively impaired tenants go into the courtyard area unsupervised. Tenant #1 eloped from the program when the egress/alarm system had been deactivated.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. (IAC r. 481-69.32(2))

B. Criteria for Admission and Retention

Complaint/Incident Allegation: The program reported one tenant eloped from the program without staff member knowledge of his/her whereabouts for an extended period of time.

- Monitoring Observation: The program reported two tenants, Tenant #1 and Tenant #2, wandered throughout the secured memory care unit. Tenant #2 often repeatedly pushed on the egress bars of the doors exiting into the enclosed courtyard. The program reported Tenant #1 had never eloped from the program. The program reported Tenant #1 exhibited exit seeking behaviors and repeatedly pushed on the egress bars of the door exiting into the general population area of the building and the doors exiting into the enclosed courtyard, often times pushing on the bar for 15 seconds, releasing the lock and allowing exit from the building or into the general population area. The program reported Tenant #1 exited into the enclosed courtyard on 3-9-13 when staff members deactivated the alarm system to the courtyard doors. Staff #2 reportedly witnessed Tenant #1 in the courtyard and watched from inside the building as Tenant #1 exited out of an unlocked gate. Staff #2 was unable to open the gate and lost visualization of Tenant #1. Tenant #1 was located in a residential neighborhood behind the program approximately 40 minutes later.

  Tenant #1, a 67 year old, was admitted to the program on 3-4-13 with the diagnoses of prolonged Post Traumatic Stress Disorder (PTSD), Alzheimer's Disease, Diabetes and Hypertension. Tenant #1 resided in the secured memory care unit. Tenant #1 scored a 6 on the Global Deterioration Scale (GDS) completed on 2-25-13, indicating severe cognitive decline.

According to the initial evaluation, completed on 2-25-13, Tenant #1 required staff member assistance with bathing, grooming, dressing and medication assistance. Tenant #1 was independent with toileting after staff reminders and ambulation without a device. Tenant #1 paced, wandered and was disoriented.

According to the Nurse's Notes, dated 3-4-13, Tenant #1 was unable to answer any questions. Tenant #1 spoke in words but could not formulate sentences or use appropriate words in content. Tenant #1 exhibited occasional agitation but had been easily redirected according to Tenant #1's caregiver report. The caregiver reported Tenant #1 paced when agitated.

According to the service plan, dated 2-26-13, Tenant #1 required 24 hour supervision in the dementia unit and indicated Tenant #1 paced when anxious, called everything "puppies", often asked if people were killing things and asked often if he/she was dead.

During interview, Staff #5, Assistant Gardens Coordinator, reported she worked in the secured memory care unit routinely and was familiar with Tenant #1. Staff #5 reported she worked in the unit on 3-8-13. Tenant #1 was more agitated on 3-8-13 than he/she had been upon admission, was wandering throughout the Gardens and exit seeking.

During interview, Staff #2, Universal Worker, reported she worked on 3-4-13, 3-7-13 and 3-8-13. Staff #2 reported Tenant #1 was pacing a lot and exit seeking all three days. On either 3-7-13 or 3-8-13 Staff #2 reported the Health Care Coordinator called back to the unit asking if Staff #2 knew where Tenant #1 was. The Health Care Coordinator reported Tenant #1 was in the general population area and had gone through the door without setting off the alarm. Staff #2 reported checked the alarm and it was in working order so she believed the door had not completely latched when someone went out thereby allowing Tenant #1 to open the door without sounding the alarm. Staff #2 reported Tenant #1 attempted to exit from the door exiting to the general population area and the two side doors exiting to the enclosed courtyard. Staff #2 reported when she and Staff #3, Universal Worker, worked, they would watch to see which door Tenant #1 was attempting to go out and then deactivate the egress/alarm system by turning off the system with a key. Both staff members would allow Tenant #1 to go in and out of the courtyard and watch him/her from inside the building through the windows, letting him/her in when Tenant #1 came to another door. If Tenant #1 went to one door more often than another to reenter the building, both staff would reportedly deactivate the egress/alarm system with the key to that door as well. Staff #2 reported Tenant #1 was easily redirected until 3-7-13. Tenant #1 became more agitated, harder to redirect and began pacing so much it was difficult to get him/her to sit down to eat. Staff #2 reported the courtyard door egress/alarm system was deactivated during the day shift on 3-7-13 and 3-8-13 due to Tenant #1's repetitive attempts to exit. Tenant #1 was allowed to go out into the courtyard unattended on the 7th and 8th.

During interview, Staff #6, Universal Worker, reported she worked both in the memory care unit and the general population area. Staff #6 reported on 3-9-13 at approximately 9:30 a.m. she entered the office by the program's main entrance into the general population area and had been inside the office for approximately one minute when she heard another staff member yell "I need help". When Staff #6 exited the office she observed Tenant #3, a cognitively impaired tenant (GDS 4) who resided in the memory care unit and used an electric wheelchair, was in-between the two doors of the main entrance and appeared to be reentering the building from the outside. Tenant #3 was facing the inside of the building and Tenant #1 was standing behind Tenant #3 and facing the inside of the building. The alarm was not sounding. Both staff members went to the two tenants and redirected them inside the building. Staff #6 called back to the memory care unit to report Tenant #1 and Tenant #3 were outside of the unit. Staff #2 and Staff #3 were working. Neither of them was aware of the two tenants being gone from the unit. Both tenants were returned to the unit.

According to the Event History Report, on 3-9-13 at approximately 10:00 a.m. Tenant #1 pulled the fire alarm in the memory care unit.

During interview, Staff #2 reported on 3-9-13 at approximately 8:45 a.m. Staff #3 deactivated all three courtyard exit door egress/alarm systems as Tenant #1 was pushing on the egress bars sounding the alarm. Staff #2 verified Tenant #1 pulled the fire alarm, sounding the alarm throughout the building at approximately 10:00 a.m.

During interview, Staff #3 reported she entered Tenant #4's apartment at approximately 10:15 a.m. to assist Tenant #4 with a shower, grooming and dressing. Staff #3 reported the door to Tenant #4's apartment would have been closed while performing the personal care assistance.

According to the Time Card Report, Staff #2 punched out at 10:30 a.m. for lunch and punched back in at 11:00 a.m. Staff #2 indicated she left the secured memory care unit during her lunch break and did not have another staff member replace her for unit coverage. When Staff #2 returned to the unit, she reported going to Tenant #4's apartment, noting the door to the apartment remained closed. Staff #2 reported she looked up and saw Tenant #1 standing out in the courtyard with the south side door open. Staff #2 reported she stood and watched Tenant #1 and assumed Tenant #1 would walk around through the courtyard as usual. When Tenant #1 did not come around to another door, Staff #2 went to the south door where Tenant #1 had gone out and saw that Tenant #1 had gone out through the south gate. Staff #2 reported she could not figure out how to open the gate so reentered the Gardens, stopped at Tenant #4's apartment to report the incident to Staff #3 then left the Gardens and went out to a door in the general population area that exits to the same area as the south gate. Staff #2 reported she looked out but didn't see Tenant #1 so she continued down the 200 hall to the door at the end of the building. Staff #2 went outside and looked for Tenant #1 but was unable to locate the tenant.

During interview, Staff #3 reported she was in Tenant #4's apartment at approximately 11:00 a.m. preparing medications for administration when Staff #2 entered and reported Tenant #1 was missing. Staff #3 reported she immediately went outside to the courtyard to look for Tenant #1, went out the unlocked south gate and walked to the end of the fence. Staff #3 reported she could not locate Tenant #1.

Staff #3 had Staff #7, Universal Worker, come to the unit to stay with the other tenants and Staff #3 went outside to search for Tenant #1. At this time, Staff #3 notified the Manager and Health Care Coordinator of the elopement.

During interview, Staff #6 reported she received a call from Staff #3 sometime just before 11:00 a.m. asking if Tenant #1 had been seen up in the general population area. Staff #6 went to the memory care unit immediately, noting all three courtyard doors were deactivated as noted by green lights present above each door. Staff #6 looked in the unit and courtyard without locating Tenant #1. Staff #6 and other staff members then began looking in the general population area and the immediate building grounds outside for Tenant #1. Staff members were unable to locate Tenant #1. Staff#6 reported walking along a very steep ditch that ran along East 18th Street away from the program.

(During observation, the monitor noted the program was surrounded by fields to the north, south and west. Across the fields to the west of the building was the beginning of residential neighborhoods. Across the fields to the south west was a county highway with a posted speed limit of 55 miles per hour. The program faced East 18th Street which was separated by a very steep ditch. East 18th Street had a posted speed limit of 35 miles per hour.)

When Staff #6 reported when she got to the end of the ditch and almost to the first neighborhood street, a citizen approached Staff #6 and reported seeing an older man without a coat wandering around the neighborhood on Troy Street carrying something. The man appeared to be confused and lost. The citizen took Staff #6 to Troy Street but was unable to locate Tenant #1. Staff #6 called into the program to report the last location seen and then drove around for approximately 5 minutes with the citizen looking for Tenant #1. She met up with the program Manager and continued to search for Tenant #1 with the Manager without ever locating Tenant #1.

During interview, Staff #3 reported she was notified by telephone that Tenant #1 was seen in the neighborhood to the west of the building so she ran across the field to the neighborhood and began whistling and calling for Tenant #1. Tenant #1 emerged from the back yards of houses located between the first and second residential streets west of the program. Tenant #1's shoes were muddy and pants were wet. Tenant #1 was dressed in shoes, socks, jeans and a long sleeved shirt. Tenant #1 was carrying a volley ball, a tennis ball, two pop cans and something he/she had taken from the memory care unit. Tenant #1 did not appear to be harmed in anyway and was immediately returned by car to the program, arriving at 11:38 a.m. in the morning.

(During observation, the monitor noted three residential streets, Edgewood, Oakwood and Highridge, were to the west of the program. If headed south on the third furthest street, Highridge, Troy Street (where the citizen had seen Tenant #1) was two blocks down. Tenant #1 was found coming from houses located on Oakwood which was approximately 0.2 miles from the program.)

The Health Care Coordinator performed a health assessment on Tenant #1 immediately following the incident, noting no injury.

The program had elopement procedures in place for staff members to follow should an elopement occur. The procedures included checking the inside and outside of the program, notify the Health Care Coordinator and the Manager and assure all other tenants were safe and secure. The program staff followed the written procedures according to direction.

According to the State Climatologist, the weather on 3-9-13 at 11:35 a.m. was 100 percent humidity, light rain, 41 degrees with winds from the southeast at 13 miles per hour with gusts up to 21 miles per hour resulting in a wind chill of 34 degrees.

During interview, Staff #2 and Staff #7 both reported Tenant #1 exited the memory care unit via the exit door leading to the general population area by pulling on the magnet at the top of the door and opening the door without sounding the alarm on 3-18-13. The Health Care Coordinator saw Tenant #1 come through the door and was able to supervise and return the tenant to the unit.

During interview, Staff #6 reported since elopement on 3-9-13, Tenant #1 had exited the memory care unit via the exit door leading to the general population area by pulling on the magnet at the top of the door and opening the door without sounding the alarm several times.

The incident report, dated 3-12-13, indicated Tenant #1 tried taking another tenant's shoe and then punched the other tenant in the shoulder. Staff members identified no injury to the other tenant.

The incident report, dated 3-13-13, and interview with Staff #7 revealed Tenant #1 pushed the egress bar on the south door to the memory care enclosed courtyard for 15 seconds and was able to go outside. Staff #7 walked along with Tenant #1 to assure safety. Before Staff #7 could get Tenant #1 back inside, Tenant #1 fell on the ice. The fall resulted in no injury.

During the on-site investigation, the monitor observed Tenant #1 attempt to leave the memory care unit as the monitor was entering. Tenant #1 held a firm grasp on the door and refused to let go of the door. After approximately one minute, Tenant #1 let go of the door and walked down the hall with the monitor. The monitor also observed Tenant #1 push the egress bar on the door exiting into the general population area. Tenant #1 pushed until the door released. Staff members attempted to keep Tenant #1 in the unit but were unsuccessful. Tenant #1 went to the main front entrance of the building and stepped outside. Staff members stayed with Tenant #1 until he could be redirected to return to the building.

Tenant #1 was exit seeking within a three days of admission. Tenant #1's agitation worsened and the pacing and attempts to exit seek increased on March 7 and 8, 2013. Staff members deactivated the door alarms to allow Tenant #1 to enter into the unsecured courtyard despite the tenants increased exit seeking. Tenant #1 eloped from the unit twice on 3-9-13, allowing another cognitively impaired tenant to elope from the unit at the same time during the first 3-9-13 incident. Since the elopement, Tenant #1 continued to pace, exit seek and exit from the unit multiple times into the courtyard and/or the general population area. Tenant #1 hit another tenant once after the elopement.

The program's system failed to prevent Tenant #1 from eloping and Tenant #1's continued attempts to exit seek place him/her at a high risk for future elopements.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who is dangerous to self or other tenants or staff, including but not limited to a tenant who despite intervention chronically elopes or displays behavior that places another tenant at risk. (IAC r. 481-69.23(1)c.(1)(2))