IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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Complaint/Incident Intake #:
50068-I

November 20, 2014

Mr. Jeffrey Schmidt, Administrator
Aase Haugen Assisted Living
8 Ohio Street
Decorah, IA 52101

RE: Final Complaint/Incident Investigation Report, Aase Haugen Assisted Living, Decorah, Iowa

Dear Mr. Schmidt:

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 **November 12, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Life Safety.

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/emailed to DIA to my attention 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 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0133	A. BUILDING: _____ B. WING _____	C 11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AASE HAUGEN AL	8 OHIO STREET DECORAH, IA 52101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 15 Number of tenants with cognitive disorder: 1 Total population of program at time of on-site: 16 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 5 Total population of program at time of on-site: 6 Total census of Assisted Living Program: 22 The following regulatory insufficiency was cited during the investigation of Incident #50068-I:	A 000		
A 138	481-69.32(2)a Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: a. Written procedures regarding alarm systems and appropriate staff response when a tenant ' s service plan indicates a risk of elopement or a tenant exhibits wandering behavior.	A 138		

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A 138	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on a tenant file review, staff interviews and a typed statement, monitor observation, weather information and review of Program documents the Program failed to have an operating door alarm system connected to each door in a dementia-specific program. The incident with Tenant #1 indicated in the Program ' s self-report, that the incident was not witnessed and it could not be determined which door Tenant #1 exited. Tenant #1 resided in the dementia specific unit which was required to operating door alarms. According to staff, the alarms did not sound when Tenant #1 left the building. There was an issue with the door leading into the dementia unit from the general population at the time of the incident. Tenant #1 wore an alarm for a wandering monitoring device and resided in the dedicated dementia unit which had door alarms. Tenant #1 exited the building without staff knowledge on 9-25-14 and no alarms sounded. 1. Tenant #1, a 94 year old, was admitted on 7-9-13 and diagnoses included: dementia, hyperlipidemia, osteoporosis and arthritis of foot (degenerative). Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. The service plan dated 7-2-14 dated reflected staff was to monitor Tenant #1 for wandering and exit seeking and Tenant #1 required an escort outside of the dementia unit. Tenant #1 ambulated independently without any assistive devices. According to an Elopement Resident form, on 9-25-14, Tenant #1 was last seen sleeping in Tenant #1's bed at 9:30 a.m. Tenant #1 was	A 138		

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A 138	Continued From page 2 returned to the building at 10:05 a.m. by a person who was not employed by the Program. Tenant #1 was wearing a wandering monitoring device on Tenant #1's ankle. According to monitor observation, it was approximately 90 feet from the dementia unit door to where Tenant #1 was found in the parking lot across the street. According to a weather website, the weather on 9-25-14 at 10:00 a.m. at the Decorah Airport was 64.4 degrees and a dew point of 53.6. Wind was approximately six miles per hour, it was overcast and there was no precipitation. 2. According to the Nurse's typed statement, the Maintenance Supervisor was there checking on the outside door because staff reported having difficulty opening the door earlier in the day around 7:00 a.m. A person who was not employed by the Program was across the street and was in the parking lot when Tenant #1 approached and asked for help. The person walked Tenant #1 to the Program. Staff reported the door alarm never sounded. Tenant #1's vital signs were as follows: blood pressure 142/88, pulse rate 102, respiration rate 18 and temperature 97.5 (tympanic). Tenant #1 denied discomfort and had no reported injuries. A skin assessment revealed no injuries. Two staff either left or entered the dementia unit during the window of time Tenant #1 left the building without the alarms sounding. The Nurse's typed statement indicated at 9:30 a.m. Staff A left the dementia unit with another tenant to go to the beauty shop. Staff A met Staff C from laundry in the dementia unit hallway, with a cart of linen to be folded.	A 138		

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A 138	Continued From page 3 An interview with the Nurse on 11-12-14 at 10:11 a.m. said she believed Tenant #1 went out the door that led to the hallway between the general population and the dementia unit. That door had issues before and if Tenant #1 was able to go out that door without an alarm going off. (The door in the center of the hallway between the dementia specific unit and the general population unit, was not alarmed at the time of the incident; however, it was alarmed at the time of the investigation.) An interview with the Nurse on 11-12-14 at 2:42 p.m. indicated after the incident with Tenant #1 it was revealed (regarding the door going into the dementia unit from the general population) when the code was entered and the door was shut it was not alarming and the door could be opened. The Nurse said once it was realized, they had staff at the door until it was corrected. According to an interview with Staff A on 11-12-14 at 1:30 p.m., on the morning of the incident with Tenant #1 she had been getting tenants up and out for breakfast from 7:00 a.m. to 9:30 a.m. Staff A took another tenant to the beauty shop and came back at 9:50 a.m. Staff A was walking towards the kitchen and the Maintenance Supervisor said there was someone out there while looking at the end door. (He was referring to Tenant #1 being returned to the building). Staff A was not aware Tenant #1 had left the building. According to an interview with Staff B on 11-12-14 at 12:49 p.m., Staff B said at 9:45 a.m. she was assisting another tenant and heard an alarm at the end of the hallway by the laundry room. Staff B said a person had brought Tenant #1 back to the Program. Staff B was not aware Tenant #1 had left the building. Staff B said she	A 138		

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A 138	Continued From page 4 did not know the specifics of the door issue but there was an issue with the dementia unit door going to the general population. Staff B did not identify hearing any other alarms except when Tenant #1 was brought back into the building. 3. According to a Program document on 9-29-14 the time was adjusted down on the two auxiliary keypads from 10 seconds to 2 seconds. The Program was not aware the countdown on the auxiliary keypad on the assisted living side (general population) was counting down first then the wandering monitoring keypad controller box had its own countdown. When the time was adjusted the door locked when closed. The Maintenance Supervisor said the when door was opened it would not alarm for 40 seconds (20 seconds on each side of the door) even if a person went through and the door shut. According to the Life Safety for Dementia Specific Program policy, an operating alarm was connected to each exit door in the dementia specific unit. A wandering monitoring system was used in the dementia unit where all tenants were issued an alarm placed on their person. The alarm would activate the door alarm system when a tenant attempted to exit unattended.	A 138		