IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 50425-I
50767-I
49460-C
50260-C
50463-C

November 24, 2014

Ms. Rhonda Allen, Manager
Parker Place Retirement
707 Hwy 57
Parkersburg, IA 50665

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - PARKER PLACE RETIREMENT
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Allen:

I. Final Complaint/Incident Investigation Report – Parker Place Retirement, Parkersburg, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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 **October 21, 22, 27 & November 17, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Program Policies and Procedures, Staffing, Criteria for Admission and Retention and Tenant Documents.

Parker Place Retirement ("Program") is being assessed a **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.17(1)(b), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received a Regulatory Insufficiency in the area(s) of Program Policies and Procedures.

The determination of a **$2,000 civil penalty** is based upon repeated regulatory insufficiency in the area(s) of: Program Policies and Procedures. As the enclosed Report details, a tenant eloped two times in one day. Another tenant eloped on another day. Staff failed to follow program's policies and procedures.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **one thousand three hundred dollars ($1,300)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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.

IV. Conclusion

The Program is being assessed a **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

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
	S0300	A BUILDING: _____ B WING _____	C 11/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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: 18 Number of tenants with cognitive disorder: 2 Total Population of Progrm at time of on-site. 20 Dementia-Specific Program by Dedication: Number of tenants without cognivite disorder 0 Number of tenants with cognitive disorder: 12 Total Population of Progrm at time of on-site: 12 Total census of Assisted Living Program: 32 The following regulatory insufficiencies were cited during the investigation of Incidents #50425-I and #50767-I and Complaints #49460-C, #50260-C and #50463-C	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on review of incident reports, program documents and interviews with staff and the	A 003		

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A 003	Continued From page 1 Manager, staff failed to follow their Elopement Policy for two of seven tenants reviewed. (Tenants #1 and #7). Per review of Incident Reports, review of a Program Document, interviews with staff and the Manager, staff did not follow the Program ' s elopement policy and procedure as established by the Program. Findings include: Tenant #1, a 71 year old, was admitted on 10-4-14 and diagnoses included: Coronary Artery Disease, Dementia, Depression, Diverticulosis, Esophageal Reflux, Extremity Atherosclerosis with Intermittent Claudication, Foot Pain, Former Smoker, Hypercholesterolemia, Pre-Diabetes, Squamous Cell Carcinoma to Dorsum Left Hand, Various Moles Temple Area of Face, Stroke Syndrome, Papillary Muscle Hypertrophy, Carotid Level B by Doppler, Glucose Intolerance (Malabsorption), Gluteal Tendonitis, History of Viral Warts, Snoring, Carotid Thrombo and Arterrectomy, Colonoscopy (Polyp) Appendectomy and Laceration of Liver. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. According to Tenant #1 ' s service plan, Tenant #1 could walk without assistance and wandered often. After Tenant #1 eloped twice from the Program on the same day, the service plan was updated to include 15 minute visual checks, documenting location and time of visual check. The service plan also directed Staff to visually check any exit when alarms sounded. According to an Incident Report dated 10-19-14 at 8:00 a.m., Staff #1 was in the dementia unit and went to take the trash out and was stopped by an employee of the convenience store with	A 003		

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A 003	Continued From page 2 Tenant #1 behind him. Tenant #1 had been across the street at the convenience store. She believed Tenant #1 followed the cook out when the cook left the dementia unit. The door was cleared by the cook. The southwest door (in the general population) was also going off and was not reset. Tenant #1 was back about 8:25 a.m. A staff was assigned to watch the doors the rest of the shift. According to an Incident Report dated 10-19-14 at 6:00 p.m., Staff #1 indicated there was a phone call from the county sheriff ' s office asking if the Program had a missing tenant. She looked and realized Tenant #1 was not accounted for. Staff #4 drove to the convenience store and picked up Tenant #1. Staff #1 was interviewed and stated she was in the kitchen helping with breakfast and the pager sounded a little after 8:00 a.m. She thought it was the cook leaving and did not check the exit doors. Later, she was in the general population talking to a staff when an employee from the convenience store came into the building with Tenant #1. Tenant #1 had been at the nearby convenience store. She took Tenant #1 to the dementia unit and called the Manager. That evening, Staff #1 was in the staff bathroom in the dementia unit. Visitors were going in and out all night. The pager sounded. She checked the door and thought it must have been another tenants ' family so she didn ' t check on the tenants, she just kept working. A staff told her the sheriff ' s office was on the phone and they had someone wearing a red shirt, jeans and socks. Staff #1 said that was Tenant #1 Another staff went to the convenience store and brought Tenant #1 back. Tenant #1 did not have any injuries. Staff #1 did not know how long Tenant	A 003		

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A 003	Continued From page 3 #1 had been gone. Staff #2 was interviewed and stated she came to work at 3:00 p.m. She was delivering a supper tray and was in the kitchen. The southwest exit door and the south dementia unit door alarms were going off. A tenants ' family was going out and coming in. She saw the family leave and thought the family set off the alarm. Staff #2 did not respond to the alarm. Staff #3 was interviewed and stated she worked the morning shift on Sunday and her pager showed the south door alarm and she also heard it was cleared. The Manager was interviewed and stated at 8:45 a.m. on Sunday, Staff #1 called and said Tenant #1 had eloped. Staff #1 was coming in and saw a convenience store employee bring Tenant #1 back. At 6:00 p.m. Staff #1 called and said the sheriff called and would be bringing Tenant #1 back to the Program from the convenience store. The Manager said Tenant #1 had made no elopement attempts since that evening. According to a Program document signed by the Manager, she spoke with Staff #1 who knew staff went out the memory care door but didn ' t check to see if anyone else had gone out the door. Staff #1 was unaware Tenant #1 was missing. She did not check the southwest door or request assistance for someone to check the southwest door. Regarding the second incident, Staff #1 said there was lots of activity in the dementia unit. She saw a family member leave and cleared the door alarm on her walkie when it paged through. Shortly after, the southwest door alarm went off. (This alarm was inaudible and went to staff pagers.) Staff #1 did not check the door or call for	A 003		

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A 003	Continued From page 4 assistance. Staff #2 was working in the general population area and checked the door alarm. She walked out the front door and saw the family leave. She did not see anyone else outside. According to a document signed by the Manager, the Manager indicated in regards to Tenant #1's elopement at approximately 8:25 a.m., the dementia unit door alarm did go off as did the southwest door alarm (in the general population). Staff did not respond appropriately to the alarm. After an investigation, it was determined staff did not follow policies and procedures. In regards to the second incident at 5:35 p.m., Tenant #1 followed another tenants ' family through the dementia unit door and out the southwest door and walked down the street to the convenience store. Staff did check the door and was aware of the family leaving. The dementia unit door alarm did go off as did the southwest door alarm. Staff did check the doors and saw a family member leave Tenant #7, a 90 year old, was admitted on 10-31-13 and diagnoses included· Dementia, Hypertension, Depression, History of Transient Ischemic Attack, Incontinence and Hematuria. Tenant #7 was staged at a six on the GDS which indicated severe cognitive decline Tenant #7 resided in the dementia unit. According to Tenant #7's service plan, Tenant #7 walked independently and did better with no assistance than when staff attempted to help. Tenant #7 appeared to be getting more unsteady/weaker when walking. Staff were to report any falls or increasing weakness. Tenant #7 often wandered into others' apartments. Staff were to redirect out to the common area. Tenant #7 was on 15 minute visual checks.	A 003		

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A 003	Continued From page 5 According to an Incident Report dated 11-15-14 at 6:02 p.m., Staff #6 reported at around 5:50 p.m. another tenant set off the north dementia unit door (alarm). Staff #6 cleared it and brought the tenant to the commons area. Staff #5 was in the general population area between 5:45 p.m. and 6:00 p.m. Staff #5 returned and Staff #6 went to break and punched out at 6:01 p.m. and then went out the front door at 6:02 p.m. and saw Tenant #7 on the left side of door outside about 10 feet from her. She brought Tenant #7 into the building to the dementia unit. According to a Code Alert/Alarm Response Report, the north dementia unit door alarmed at 17:42:18 (5:56 p.m.) and was cleared at 17:42:20, 2 seconds later. The Program identified this time as the time Tenant #7 exited the north dementia unit door. At 17:43:28 (5:57 p.m.) the northeast exit door (general population) alarmed. The alarm was reset after 34 minutes and 5 seconds. At 17:48:51 (6:02 p.m.) Staff #6 left to go on break through the south memory door. At 17 50:42 (6:04 p.m.) Staff #6 exited the main entrance. At 17:51:25 (6:05 p.m.), Staff #6 returned through the main entrance doors with Tenant #7. (The Manager stated the alarm response clock recorded 14 minutes earlier than actual time. The real time was reflected in parentheses above behind the military time reflected.) Tenant #7 was outside from 5:57 p.m. until 6:05 p.m. for a total of eight minutes. Staff #6 was interviewed on 11-17-14 at 4:52 p m. She stated she worked Saturday evening (11-15-14) and at around 5:45 p m. a tenant walked to the north dementia unit door and pushed on the bar. She turned the tenant around and heard the door beep so she thought it had reset. At 5:35 p.m. Tenant #7 had been at the the	A 003		

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A 003	Continued From page 6 south dementia unit door and went into another tenant's room. Staff #6 directed Tenant #7 to Tenant #7's room. She went to the dining room area and Staff #5 was called to the general population. Staff #5 returned around 6:00 p.m. so Staff #6 went on break. She punched out and went outside at 6:01 p.m. She saw Tenant #7 outside about 10 feet from the front door. Tenant #7 said "I'm cold and can't get in the door." She helped Tenant #7 into the building to the dementia unit. Tenant #7's nose was a little red. Staff #5 gave Tenant #7 a blanket and coffee. Tenant #7 was wearing a black shirt, glasses, jogging pants, socks and brown slippers. Tenant #7's hands were cold but Tenant #7 had no injuries. Investigating how Tenant #7 exited, she saw footprints in the snow going from the northeast exit door, along the (east) side of the building. Staff #5 was interviewed on 11-17-14 at 4:38 p.m. and said she had been outside with a tenant from the general population and took the tenant back to the tenants' apartment. She had seen Tenant #7 in the commons area before she took the other tenant outside at 5:47 p.m. She was outside long enough for the tenant to smoke a cigarette. She said it was really cold and snowy. She came back inside and took the tenant to room 318 in a wheelchair She did not see anyone in the halls. She returned the wheelchair to the front lobby and then went to the dementia unit. Staff #6 left for break at 6:01 p m. She saw the north dementia alarm go off and Staff #6 had cleared it and said it was another tenant. This occurred while she was in room 318. When Staff #6 returned from break she had Tenant #7 with her. Staff #5 did a head count and no one else was missing. She wrapped Tenant #7 in a blanket and gave him/her coffee and a brownie She stated Tenant #7 did not have any injuries.	A 003		

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A 003	Continued From page 7 The Manager was interviewed on 11-15-14 at 5:12 p.m. and stated she had called Staff #5 around 6:15 p.m. to reset the northeast door due to an escalated call that came to her cell phone. Staff #5 called back and said the staff had found Tenant #7 outside. They thought Tenant #7 went out the north dementia care door, northeast exit and Staff #6 found Tenant #7 when she went outside for her break. The Manager came into the Program around 7:00 p.m. and checked on Tenant #7 who was in bed and sleeping. Tenant #7 did not have any injuries. According to a document signed by the Manager, the Manager indicated in regards to Tenant #7's elopement, she asked staff if they knew Tenant #7 was outside prior to Staff #6 finding Tenant #7 and staff said no. According to the Elopement Policy, the Procedure was as follows: If any door alarm sounds check alarms promptly. Thoroughly check inside and outside areas triggered by the alarm. Fill out an incident report and document on any elopement or attempted elopement If a potential elopement had occurred and the tenant was not seen, completely search the community checking all apartments, offices, closets, bathrooms and common areas. The manager or nurse would call the family to see if the tenant was with them. The community would also conduct an outside search. If the tenant still was not found the manager or nurse would notify the local law enforcement. The manager or nurse would notify the family once the tenant was found.	A 003		
A 055	481-67.9(1) Staffing	A 055		

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A 055	Continued From page 8 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, incident reports and interviews with staff and the Manager, the program failed to have a sufficient number of trained staff available to meet the tenants' identified needs. Per review of Tenant #1 and Tenant #7 ' s files, review of incident reports, interviews with staff and the Manager, Tenant #1 eloped twice in one day without staff knowledge and Tenant #7 eloped without staff knowledge. Staff did not meet Tenant #1 and Tenant #7 ' s identified needs. According to an Incident Report dated 10-19-14 at 8:00 a m., Staff #1 was in the dementia unit and went to take the trash out and was stopped by a person with Tenant #1 behind him. Tenant #1 had been across the street at the convenience store and store staff brought Tenant #1 back to the Program. Staff #1 believed Tenant #1 followed the cook out when the cook left the dementia unit. The door was cleared by the cook. The southwest door (in the general population) was also going off and was not reset. Tenant #1 was back about 8:25 a.m. A staff was assigned to watch the doors the rest of the shift. According to an Incident Report, dated 10-19-14 at 6:00 p.m., Staff #1 indicated there was a phone call from the county sheriff ' s office asking if the Program had a missing tenant. She looked and realized Tenant #1 was not accounted for. Staff #4 drove to the convenience store and picked up	A 055		

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A 055	Continued From page 9 Tenant #1. Staff #1 was interviewed and stated she was in the kitchen helping with breakfast and the pager sounded a little after 8:00 a.m. She thought it was the cook leaving and did not check the exit doors. Later, she was in the general population talking to a staff when an employee from the convenience store across the street, came into the building with Tenant #1. Tenant #1 had been at the convenience store. She took Tenant #1 to the dementia unit and called the Manager. That evening, Staff #1 was in the staff bathroom in the dementia unit. Visitors were going in and out all night. The pager sounded. She checked the door and thought it must have been another tenants ' family, so she didn ' t check on the tenants, she just kept working. A staff told her the sheriff ' s office was on the phone and they had someone wearing a red shirt, jeans and socks. Staff #1 said that was Tenant #1. Another staff went to the convenience store and brought Tenant #1 back. Tenant #1 did not have any injuries. Staff #1 did not know how long Tenant #1 had been gone. Staff #2 was interviewed and stated she came to work at 3:00 p.m. She was delivering a supper tray and was in the kitchen. The southwest exit door and the south dementia unit door alarms were going off. A tenants ' family was going out and coming in. She saw the family leave and thought the family set off the alarm. Staff #2 did not respond to the alarm. Staff #3 was interviewed and stated she worked the morning shift on Sunday and her pager showed the south door alarm and she also heard it was cleared.	A 055		

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
	S0300	A. BUILDING: _____ B. WING _____	C 11/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(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 055	Continued From page 10 The Manager was interviewed and stated at 8:45 a.m. on Sunday Staff #1 called and said Tenant #1 had eloped. Staff #1 was coming in and saw a convenience store employee bring Tenant #1 back. At 6:00 p.m. Staff #1 called and said the sheriff called and would be bringing Tenant #1 back to the Program from the convenience store. The Manager said Tenant #1 had made no elopement attempts since that evening. According to a Program document signed by the Manager, she spoke with Staff #1 who knew staff went out the memory care door but didn ' t check to see if anyone else had gone out the door. Staff #1 was unaware Tenant #1 was missing. She did not check the southwest door or request assistance for someone to check the southwest door. Regarding the second incident, Staff #1 said there was lots of activity in the dementia unit. She saw a family member leave and cleared the door alarm on her walkie when it paged through. Shortly after, the southwest door alarm went off. (This alarm was inaudible and went to staff pagers.) Staff #1 did not check the door or call for assistance. Staff #2 was working in the general population area and checked the door alarm She walked out the front door and saw the family leave. She did not see anyone else outside. According to a document signed by the Manager, the Manager indicated in regards to Tenant #1's elopement at approximately 8:25 a.m., the dementia unit door alarm did go off as did the southwest door alarm (in the general population). Staff did not respond appropriately to the alarm. After an investigation, it was determined staff did not follow policies and procedures. In regards to the second incident at 5:35 p.m., Tenant #1 followed another tenants ' family through the dementia unit door and out the southwest door	A 055		

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A 055	Continued From page 11 and walked down the street to the convenience store. Staff did check the door and was aware of the family leaving. The dementia unit door alarm did go off as did the southwest door alarm. Staff did check the doors and saw a family member leave. A floor plan of the building was provided. The monitor walked the possible route taken by Tenant #1 at approximately 8:00 a.m. from the dementia unit, through the south dementia alarmed door, out the southwest exit door to the convenience store. The distance walked was approximately 405 feet. A similar route was probably taken at approximately 5:00 p.m. on the same day. According to the State Climatologist on 10-19-14 at 7:54 a.m. at the Waterloo airport the temperature was 37 degrees with winds out of the south at seven miles per hour, wind chill of 32 degrees and clear skies. At 4:54 p.m. the temperature was 64 degrees with winds from the south and wind gusts to 23 miles per hour. At 5:45 p.m. the temperature was 62 degrees, winds from the southwest at 13 miles per hour and clear skies. According to a Program Document, on 10-22-14, an audible alarm was added to the southwest exit door. Emergency only exit door signs were placed on all exit doors within the Program. Audible alarms were ordered on 10-23-14 for all exit doors to be installed once received. A mandatory all staff in-service was held on 10-23-14 regarding Elopement Policy and Procedures. Regarding Tenant #7's elopement: According to	A 055		

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A 055	Continued From page 12 an Incident Report dated 11-15-14 at 6:02 p.m., Staff #6 reported at around 5:50 p.m. another tenant set off the north dementia unit door (alarm). Staff #6 cleared it and brought the tenant to the commons area. Staff #5 was in the general population area between 5:45 p.m. and 6:00 p.m. Staff #5 returned and Staff #6 went to break and punched out at 6:01 p.m. and then went out the front door at 6:02 p.m. and saw Tenant #7 on the left side of door outside about 10 feet from her. She brought Tenant #7 in the building and took back to the dementia unit. According to a Code Alert/Alarm Response Report, the north dementia unit door alarmed at 17:42:18 (5:56 p.m.) and was cleared at 17:42:20, 2 seconds later. The Program identified this time as the time Tenant #7 exited the north dementia unit door. At 17:43:28 (5:57 p.m.) the northeast exit door (general population) alarmed. The alarm was reset after 34 minutes and 5 seconds. At 17:48:51 (6:02 p.m.) Staff #6 left to go on break through the south memory door. At 17:50:42 (6:04 p.m.) Staff #6 exited the main entrance. At 17:51:25 (6.05 p.m.), Staff #6 returned through the main entrance doors with Tenant #7. (The Manager stated the alarm response clock recorded 14 minutes earlier than actual time. The real time was reflected in parentheses above behind the military time reflected.) Tenant #7 was outside from 5:57 p.m. until 6:05 p.m. for a total of eight minutes. Staff #6 was interviewed on 11-17-14 at 4:52 p.m. She stated she worked Saturday evening (11-15-14) and at around 5:45 p m. a tenant walked to the north dementia unit door and pushed on the bar. She turned the tenant around and heard the door beep so she thought it had reset. At 5:35 p.m. Tenant #7 had been at the the	A 055		

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A 055	Continued From page 13 south dementia unit door and went into another tenant's room. Staff #6 directed Tenant #7 to Tenant #7's room. She went to the dining room area and Staff #5 was called to the general population. Staff #5 returned around 6:00 p.m. so Staff #6 went on break. She punched out and went outside at 6:01 p.m. She saw Tenant #7 outside about 10 feet from the front door. Tenant #7 said "I'm cold and can't get in the door." She helped Tenant #7 in the building and took to the dementia unit. Tenant #7's nose was a little red. Staff #5 gave Tenant #7 a blanket and coffee. Tenant #7 was wearing a black shirt, glasses, jogging pants, socks and brown slippers. Tenant #7's hands were cold but Tenant #7 had no injuries. Investigating how Tenant #7 exited she saw footprints in the snow going from the northeast exit door, along the (east) side of the building. Staff #5 was interviewed on 11-17-14 at 4:38 p m. and said she had been outside with a tenant from the general population and took the tenant back to the tenants' apartment. She had seen Tenant #7 in the commons area before she took the other tenant outside at 5:47 p.m. She was outside long enough for the tenant to smoke a cigarette. She said it was really cold and snowy. She came back inside and took the tenant to room 318 in a wheelchair. She did not see anyone in the halls. She returned the wheelchair to the front lobby and then went to the dementia unit. Staff #6 left for break at 6:01 p.m. She saw the north dementia alarm go off and Staff #6 had cleared it and said it was another tenant. This occurred while she was in room 318. When Staff #6 returned from break she had Tenant #7 with her. Staff #5 did a head count and no one else was missing. She wrapped Tenant #7 in a blanket and gave him/her coffee and a brownie.	A 055		

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A 055	Continued From page 14 She stated Tenant #7 did not have any injuries. The Manager was interviewed on 11-15-14 at 5:12 p.m. and stated she had called Staff #5 around 6:15 p.m. to reset the northeast door due to an escalated call that came to her cell phone. Staff #5 called back and said the staff had found Tenant #7 outside. They thought Tenant #7 went out the north dementia care door, northeast exit and Staff #6 found Tenant #7 when she went outside for her break. The Manager came into the Program around 7:00 p.m. and checked on Tenant #7 who was in bed and sleeping. Tenant #7 did not have any injuries. According to a document signed by the Manager, the Manager indicated in regards to Tenant #7's elopement, she asked staff if they knew Tenant #7 was outside prior to Staff #6 finding Tenant #7 and staff said no. A floor plan of the building was provided On 11-17-14 at 4:17 p.m. the monitor walked the possible route taken by Tenant #7, At approximately 5:42 p.m. Tenant #7 exited the dementia unit, through the north dementia alarmed door, out the northeast exit door, along the east side of the building around the corner and was headed to the front doors. The distance walked inside the building from the north door to the northeast exit was approximately 165 feet. Once Tenant #7 exited the northeast door, the potential route taken was approximately 228 feet along the east side of the building and an additional 42 feet to the front door. According to the State Climatologist, on 11-15-14 at the Waterloo Airport at 5:54 p.m. it was 22 degrees, winds from the south at six miles per hour, wind chill of 15 degrees and light snow was	A 055		

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A 055	Continued From page 15 falling. An In-Service on the Elopement Policy was held on 11-16-14 for all staff which focused on visual checks of exit doors, response time requirements and the elopement policy and procedure. On 11-17-14 at 5:42 p.m., The Manager stated the cords on the audible alarms had been cut so no extra string prevented the alarm from sounding Incident reports were completed for Tenants #1 and #7's elopements and the Department was notified.	A 055		
A 047	481-69.23(1)i Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: i. Requires maximal assistance with activities of daily living This REQUIREMENT is not met as evidenced by: Based on tenant file reviews, review of incident reports, staff interviews and monitor observations, the program failed to discharge a tenant who exceeded the criteria for admission and retention for one of seven tenants reviewed. (Tenant #5). Tenant #5 required maximal assistance with activities of daily living. Tenant #5 exceeded level of care. Findings include:	A 047		

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A 047	Continued From page 16 Tenant #5, a 90 year old, was admitted on 9-21-13 and diagnoses included: Dementia, Mood Disorder with Psychotic Symptoms, Parkinson ' s, HTN, Hyperlipidemia, Hard of Hearing with Bilateral Hearing Aids, History of UTI, Urinary Retention (Foley Catheter) Dislocated Right Elbow with Surgical Repair (4-20-12) History of Falls, History of Bilateral Total Knee Repairs, History of Cataract Removal, Hypothyroidism and History of Yeast Infection. Tenant #5 was staged at a six on the GDS which indicated severe cognitive decline. Tenant #5 resided in the dementia unit. According to the Nurse ' s Notes dated 6-19-14, Tenant #5 had a fall on 3-8-14 with a fractured pelvis. According to Tenant #5 ' s service plan dated 9-10-14, Tenant #5 needed assistance with showers due to history of falls and limited mobility. Staff used gait belt to transfer to shower chair, then into shower Tenant #5 could wash face with assistance and needed total assistance with all other washing. Very important for staff to do catheter care twice daily and as needed. Tenant #5 needed assistance with brushing own teeth and staff to help with grooming as needed, Tenant #5 needed assistance with dressing upper and lower body, socks and shoes. Tenant #5 had a history of falling, had recovered from a fractured pelvis but was unable to walk with a walker, needed assistance of one person and gait belt to transfer into wheelchair for mobility. Tenant #5 used wheelchair for mobility with assistance, needed assistance of one person with gait belt to transfer to wheelchair. Staff needed to use scheduled Tylenol and topical cream and as needed Tylenol as needed for leg and knee pain. Tenant #5 had a Foley catheter and needed assistance to bed side commode for BM. Tenant #5 had tremors in hands but could feed self.	A 047		

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A 047	Continued From page 17 Tenant #5 spilled and liked to have a dining scarf and lap cover when eating. Due to tremors, could drink more easily with a cup that had a lid and straw. Tenant #5 ' s family filled a medication planner and staff administered medications. Staff #1 was interviewed and stated Tenant #5 didn ' t do anything for self except feed self. She stated Tenant #5 was so stiff she didn ' t think Tenant #5 could do any cares. Staff #1 hadn ' t tried to give Tenant #5 a wash cloth. Staff #1 provided perineal care, would place partial plate in Tenant #5 ' s mouth most of the time. Tenant #5 was not able to brush the bottom partial plate or the upper teeth, could not brush teeth. Staff #1 stated she had to perform all activities of daily living for Tenant #5 all the time. Staff #2 stated Tenant #5 exceeded level of care and was a routine two person assist. She stated Tenant #5 could feed self and could wash upper body but could not brush hair, brush teeth, stand, toilet, transfer or dress self. Staff #5 was interviewed and stated Tenant #5 exceeded level of care. On 10-27-14 at 11:50 a.m., the monitor observed Staff #1 provide cares to Tenant #5. Tenant #5 was lying in a double bed with a half rail on one side, a catheter bag attached to the bed. Staff #1 washed Tenant #1 ' s eyes, provided perineal care, catheter care and applied anti-embolism stockings. The catheter bag strap was on the leg above the right knee. Lotion was applied to the legs. Staff #1 stated Tenant #5 could not walk. Staff #1 applied deodorant and assisted Tenant #5 to sit on edge of bed in order to change night gown. Tenant #5 was unable to sit up alone. Staff #1 held Tenant #5 ' s shoulder with one hand and used her other hand to change the	A 047		

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A 047	Continued From page 18 night gown. Staff #1 had Tenant #5 put one hand on the side rail, while Staff #1 held the shoulder with one hand and applied a gait belt. Staff #1 attempted to have Tenant #5 pivot without success while Staff #1 held Tenant #5 and placed Tenant #5 in the wheelchair. Staff #1 stated since Tenant #5 fell and cracked tailbone approximately six months ago, Tenant #5 had not walked. On 10-27-14 at 12:28 p.m., Tenant #5 was observed in the dining room. Staff placed a dining scarf around neck and placed a tablecloth on Tenant #5 ' s lap. The dinner plate had a food guard in place and the drink was in a covered cup with a straw. Tenant #5 was able to serve self and got food onto a fork and into mouth. Tenant #5 ate approximately half of the food on the dinner plate, a few bites of green marshmallow salad and one half of a piece of cake. Staff #3 stated Tenant #5 normally ate some of everything, usually ate about half of the food served. Staffs #1, #3 and #5 stated they had not been told to not notify family of tenant behaviors or incidents. Staff #2 stated staff was to notify the Nurse or the Manager regarding tenant behaviors or incidents. The Nurse stated staff were to notify her if there were behaviors or incidents. The Manager stated she and the Nurse wanted to be the ones who communicated behaviors and incidents with tenant families.	A 047		
A 077	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant,	A 077		

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A 077	Continued From page 19 including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant ' s medical record) This REQUIREMENT is not met as evidenced by: Based on tenant file reviews, staff interviews and Manager interview, the program failed to complete an incident report when a tenant eloped for one of seven tenants reviewed. (Tenant #6) Staff interviews indicated Tenant #6 had eloped. Review of Tenant #6 ' s file and a Manager interview indicated an incident report was not completed regarding Tenant #6 ' s elopement at the time of the elopement. Findings include: Tenant #6, an 86 year old, was admitted on 10-18-13 and diagnoses included: Dementia with Agitation, Parkinson ' s Disease, Chronic Atrial Fibrillation with Pacemaker, Alcohol Abuse, Peripheral Vascular Disease, Carotid Endarterectomy, Hyperlipidemia, Depression, History of CVA 2010, History of Seizure Disorder and Right Inguinal Hernia. Tenant #6 was staged at a five on the GDS, which indicated moderate severe cognitive decline. Tenant #6 resided in the dementia unit. Staff #1 was interviewed and stated she was turning Tenant #2 on 9-17-14 when the south door alarm sounded. She said Staff #4 saw Tenant #6 go out and she followed him. Staff #1 ran outside and saw Tenant #6 on the sidewalk across the street east of the building. She said she hopped in her car and drove across the street and asked Tenant #6 where he/she was going. Tenant #6 said " Home. " Staff #1 was able to	A 077		

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A 077	Continued From page 20 get Tenant #6 into a car and brought Tenant #6 back to the Program. Staff # 4 was interviewed and stated she did not see Tenant #6 leave the building, someone else told her Tenant #6 was missing. She said she started to look for Tenant #6 and spotted Tenant #6 east on Third Street walking on the sidewalk. She stated another staff hopped in her car and went to get Tenant #6. She stated she couldn ' t remember what Tenant #6 was wearing but was dressed appropriately for the weather and had no injuries. Staff #5 was interviewed and stated about one month prior, Tenant #6 had eloped from the dementia unit and walked to the road next door. A floor plan of the building was provided. The monitor walked the possible route taken by Tenant #6 apparently exiting the dementia unit doors, walked down the hallway, exited out the front doors, traveled east of the building through the grass, past a house, crossed the street and started to head north on the sideway. Staff #1 showed the monitor the point at which she reached Tenant #6. The distance walked was approximately 660 feet. According to the State Climatologist, on 9-17-14 at 5:54 p.m. at the Waterloo airport the temperature was 71 degrees, clear skies and calm winds. The Manager was interviewed and stated she was not aware Tenant #6 had eloped, thus she had not directed staff to complete an incident report. She stated an incident report was not completed regarding the elopement.	A 077		

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A 077	Continued From page 21 The monitor requested the incident report regarding Tenant #6 ' s elopement. The Manager informed the monitor no incident report had been completed. On 10-27-14 during the onsite investigation Program staff asked Staff #1 to complete an incident report regarding Tenant #6 ' s elopement. An incident report was not completed at the time of Tenant #6 ' s elopement that occurred on 9-17-14.	A 077		

Parker Place Retirement
707 Hwy 57
Parkersburg, IA 50665

Date: 12/2/14

Complaint Intake #: 50425-I, 50767-I, 49460-C, 50260-C 50463-C

Plan of Correction (POC) Submitted For:
- October 21, 22, 27 & November 17, 2014
- Margaret Kaltefleiter, RN M.S.

POC:

A. Program Policies and Procedures:

a. Regulatory Insufficiency: Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. 481-67.2(231B,231C,231D)

i. Program POC:

1. With respect to Tenant #1, #7 and all tenants in the program all staff will follow policy and procedures for the Elopement Policy and Procedure for all exit door alarm notifications.

2. All staff received re-education on redirection strategies the Elopement Policy and Procedure on October 26 and November 16 from the Program Manager and the Operations Manager.

3. The Manager and Program Nurse will ensure that all new employees receive and complete training on Elopement Policies and Procedures and that all staff receive ongoing education/in-service training per the community In-service Training schedule. This training will be maintained on file and annual training will be completed with all staff on-going.

B. Staffing:

b. Regulatory Insufficiency: Number of Staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. 481-67.9(231B,231C,231D) 67.9(1).

i. Program POC:

1. With respect to tenant #1, #2, #3, #5, #6, #7 and all tenants in the program the Program has sufficient number of staff on all shifts to meet the tenants identified needs.

2. The Manager and Program Nurse will review tenant's needs during the community's morning stand-up meeting to ensure that they have a sufficient number of trained staff on each shift to meet the tenants' identified needs.

3. The Program Manager and Nurse will review the staffing schedule weekly to ensure that the Program has sufficient number of trained staff on each shift to meet the tenants' identified needs. The Program Manager and Nurse will be responsible to ensure there is sufficient number of trained staff for each shift to meet the tenants' needs.

C. Criteria for Admission and Retention of Tenants:

b. Regulatory Insufficiency: Criteria for admission and retention of tenants. Persons who may not be admitted or retained. A program may not knowingly admit or retain a tenant who: 1. Requires maximal assistance with activities of daily living. 481-69.23(1)

i. Program POC:

1. With respect to tenant #5, and all tenants in the program the Program will not knowingly admit or retain any tenant that requires maximal assistance with activities of daily living. Tenant #5 is currently receiving palliative hospice services to support and assist with this tenants' needs ~~and has been given a 30 day notice~~ to seek alternative placement.

2. The Program Nurse will review current tenants' acuity changes in needs during the community's morning meeting. The Program Nurse will notify the Manager, Operations Manager and Nurse Clinician when prospective or current tenant's needs exceed admission and retention criteria.

3. The Program Manager and Nurse will consult with the Nurse Clinician as necessary to ensure admission and retention criteria is being met for prospective and current tenants.

D. Tenant Documents:

b. Regulatory Insufficiency: Tenant Documents. Documentation for each tenant shall be maintained by the Program and shall include: Incident reports involving the tenant, including by not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record. 481-69.25(231C) 69.25(1)

i. Program POC:

1. With respect to tenant #6, and all tenants in the Program the Program will complete an incident report for all incidents involving tenants. An incident report was generated as a Late Entry report for tenant #6.

2. The Manager and Program Nurse will ensure that there is an incident report generated for any incident involving a resident. All staff were re-trained on incident reporting November 6 from the Program Manager and Program RN.

3. The Program Manager and Nurse will ensure that all incidents involving a resident have an incident report completed. The Program Manager and Nurse will review all incident reports at the community's morning meeting and report as needed to the Operations Manager and Nurse Clinician. The Program Manager and Nurse are responsible to follow-up, document and notify the Department as required.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.