IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
58908-I

April 5, 2016

Ms. Kristen Milledge, Director
Homestead of Chariton
1110 North 6th Street
Chariton, IA 50049

RE: Final Complaint/Incident Investigation Report, Homestead of Chariton, Chariton, Iowa

Dear Ms. Milledge:

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 **March 29 & 30, 2016.** The Report notes a Regulatory Insufficiency in the area(s) of: Program policies and procedures.

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
	S0233	A. BUILDING: _____ B. WING _____	C 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CHARITON	1110 NORTH 6TH STREET CHARITON, IA 50049

(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: 35 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 39 TOTAL census of Assisted Living Program: 39 The following regulatory insufficiency was cited during the investigation of Incident 58908-I :	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: Incident 58908-I Based on interviews and review of documentation, the Program did not follow policies and procedures for elopement.	A 003		

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A 003	Continued From page 1 1. Tenant #1 a 92 year old was admitted on 3-29-15 and diagnoses included: dementia, hypertension and hyperlipidemia. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. An Occurrence (Incident) Report dated 3-5-16 stated a family member mentioned to staff they had observed somone walking away from the Program. Both staff on duty initiated a search for Tenant #1 and determined Tenant #1 was not in the building. Staff A contacted the on call staff while Staff B took Tenant #1's coat and got in a truck to look for Tenant #1. Staff B located Tenant #1 walking towards the Program. Staff B convinced Tenant #1 to return to the Program in her vehicle. Tenant #1 wore a wander guard but it did not activate when Tenant #1 left the building. The weather was 34 degrees and sunny. The on call nurse assessed Tenant #1. Tenant #1's son was notified and took Tenant #1 to the hospital to be checked out, including a urinary analysis. Neither staff heard the alarm go off. The Program contacted the company responsible for the device and set up a time to check the device on 3-7-16. Tenant #1 was provided 24/7 supervision until Tenant #1 moved to a program with a memory care unit on 3-10-16. Review of the Program's Policy for Elopement Prevention, and Management of Missing Residents revised 12/15 included the following statement under the heading Prevention:Verification of control systems; Each resident device is checked daily and recorded as in place and functional in the EMR (electronic medical record).	A 003		

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A 003	Continued From page 2 When interviewed on 3-30-16, the Resident Care Coordinator (RCC) confirmed the Program did not add the wander guard to Tenant #1's EMR when it was added to the service plan dated 1-27-16.	A 003		

Based on interviews and review of documentation, Program did not follow Policies and Procedures for Elopement. Tenant #1 eloped on 3/05/2016.

Plan of Correction:

1. Program will follow Policy and Procedure for Elopement. All tenants fitted with a Wander Guard bracelet will have it entered into the EMR as a task, to be checked once a day to ensure transmitter is alarming/working properly, with an additional check for correct placement on the tenant, done every shift.
2. Program RN/RCC will make sure the above tasks are entered on the EMR upon placement, and that staff is notified that it is to be done and signed off on once daily.
3. Director/RCC will audit applicable EMR for compliance.
4. Regulatory Insufficiency was corrected on 3/5/16 by adding the tasks to the EMR for checking the Wander Guard to any tenants wearing the transmitter.