IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 43251-I

May 13, 2013

Ms. Kris Ward, Acting Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52245

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - LEGACY GARDENS
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Ward:

I. Final Complaint/Incident Investigation Report – Legacy Gardens, Iowa City, 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 **April 10 and 11, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Life Safety, Program Reporting to Department, Criteria for Admission and Retention and Tenant Documents.

Legacy Gardens ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.12(3)(a)(1), (2).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), 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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) 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 determination of a **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm to a tenant; and for repeated Regulatory Insufficiencies in the area of Criteria for Admission and Retention. As the enclosed Report details, the Program failed to address Life Safety related to how the door alarms functioned and failed to assure all staff had working walkie-talkies. The Program failed to give a tenant a timely discharge notice for chronic elopement attempts despite intervention.

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 481–67.12(3)d. 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 **six hundred and fifty dollars ($650)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.12(3)(a)(1), (2). The Plan of Correction (POC) submitted on May 10, 2013, has been reviewed and will constitute the final POC related to the on-site visit of April 10 and 11, 2013.

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 within 30 days of notice or service of this letter.

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

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Kris Ward, Acting Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, Iowa 52245

Complaint/Incident Intake #:

43251-I

Date of Complaint/Incident Investigation:

April 10 and 11, 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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	19
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	21

Program History – The program received regulatory insufficiencies during the Recertification and Complaint/Incident (40184-I, 40159-C, 40187-C) on-sit of August and Sept, 2012 in the areas of: Service Plan, Medications, Nurse Review, Staffing, Policy and Procedure, Tenant Rights and Tenant Documents.

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 tenant eloped from the building unaccompanied by staff members after the alarm system and staff response was delayed.

- Monitoring Observation: According to the program's policy, titled Door and Window Alarms, all door and window alarms were to be immediately responded to in order to assure tenant safety. The alarm system would sound a message to be sent to all employee pagers with the location of the alarm when activated. Staff members responsible for the area where the alarm had sounded were to report to the location immediately. If staff members were unable to respond immediately, staff members would contact each other via a portable walkie system to request assistance with the alarm.

  The program's building had two wings, the west and the east. Each wing had two exit doors which lead to an enclosed courtyard with two gates. Each wing had one door which exited into an attached lobby located at the main entrance of the building. The main entrance of the lobby was secured, preventing unauthorized entrance or exit. The door had a keypad that could be used by staff members to bypass the secure system by putting in a common code. The door had a 15 second egress bar on the interior aspect of the door. 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. Opening of the lobby main entrance without entering the correct code would sound the alarm to the pager system, notifying the staff members of a potential elopement from the building.

Both the west and east wing doors which exited to the lobby were secured, preventing unauthorized exit. The door had a keypad located in the interior of the wing that could be used by staff members to bypass the secure system by putting in a common code. Opening either of the doors exiting to the lobby without entering the correct code would sound the alarm to the pager system, notifying the staff members of a potential elopement from the wing. Both doors also had an audible alarm which would sound for 12 seconds then automatically silence. The exterior of each wing's lobby door had a motion detector located above the door. When the detector noted movement, the door automatically disengaged, allowing entrance into the door without sounding the alarm. When the detector disengaged the alarm system, the door could also be opened from the inside without triggering the alarm system to the pagers and disengaged the audible alarm. During interview with staff members and direct observation of the alarm system, the monitor noted if a person stood in front of both the west and east lobby doors but did not enter, the alarm system disengaged from the inside, allowing unauthorized exit into the lobby area. The program mailboxes were located just outside the west wing doors. Staff members reported noting previously that if someone stood at the mail boxes, the door alarm system to the west wing disengaged.

Each of the courtyard exit doors had a keypad located in the interior of the wing that could be used by staff members to bypass the secure system by putting in a common code. Opening either of the doors exiting to the lobby without entering the correct code would sound the alarm to the pager system, notifying the staff members of a potential elopement from the wing. Each courtyard had two gates which were locked using a keyed padlock. Each staff member carried a key to the padlocks while on duty.

During interview, Staff #1, #2, #3, #4 and #5, all direct care workers, reported the program did not have enough pagers for all staff members to wear when on duty until just recently, following a tenant elopement. All five staff members also reported the portable walkie system frequently did not work as the batteries would die without warning, making the walkies inoperable.

The program reported five tenants, Tenants #1, #2, #3, #4 and #5, wandered throughout the secured memory care units. Tenants #2, #3, #4 and #5 at times would exit seek but had never eloped from the program.

Tenant #1, a 70 year old, was admitted to the program on 8-18-10 with diagnoses of: Alzheimer's Disease, Paranoia and Agitation. Tenant #1 resided in the west wing of the secured memory care building. Tenant #1 scored a 6 on the Global Deterioration Scale (GDS) completed on 3-25-13, indicating severe cognitive decline.
According to the evaluation, completed on 3-25-13, Tenant #1 required staff member assistance with bathing, grooming, dressing, toileting and medication assistance. Tenant #1 was independent with ambulation without a device. Tenant #1 wandered and exhibited exit seeking behavior.

Tenant #1 frequently exited the west wing door into the lobby and frequently exited the courtyard doors, setting off the alarm system. Tenant #1 exhibited exit seeking behaviors and repeatedly pushed on the egress bars of the lobby exit door, exiting into

the open neighborhood if not responded to immediately by staff members. During interview, Staff #1 reported Tenant #1 attempted to exit the building approximately eight times during the day shift.

On 3-21-13 at approximately 8:00 p.m., Tenant #1 exited the west lobby doors and the main entrance of the lobby, entered the open neighborhood without staff member supervision. According to the program's alarm detail, the first alarm connected to the west lobby door sounded at 7:59 p.m., the second alarm connected to the main entrance of the building located in the lobby sounded at 8:00 p.m.

During interview, Staff #4, certified nursing assistant (CNA), reported she worked on the west wing and was giving a shower to another tenant with the doors closed on 3-21-13 at 7:00 p.m. Staff #4 reported her pager alarm went off at 7:59 p.m. and again at 8:00 p.m. Staff #4 assumed the other staff members working on the west wing would respond to the alarm. After noting no response after a few minutes, Staff #4 quickly assured the tenant receiving the shower was safe and then went to respond to the alarm. Staff #4 reported she did not have a portable walkie with her as the battery had died earlier in the night.

During interview, Staff #3, nurse aide (NA), reported she passed medications on the east wing and floated over to the west wing when assistance was needed on 3-21-13. Staff #3 reported she went to the west wing at approximately 7:50 p.m. and found no staff members in the common areas. Staff #3 searched all hallways for staff finding Staff #6, licensed practical nurse (LPN), exiting another tenants room. Staff #3 reported another tenant coming down the hall asked for assistance so Staff #3 went with the tenant to his/her room to prepare for bed. During the care, Staff #3 reported needing gloves so she exited the apartment and went to the medication cart for gloves. Staff #4 came running down the hallway asking where Tenant #1 was as the alarms had sounded. Staff #6 denied hearing any audible alarm sounding. Staff #3 and Staff #6 did not have pagers on as there were not enough available for all staff members to have while on duty. Staff #6 shut the alarms off at 8:07 p.m. Staff #3, #4 and #6 looked throughout the building, in the east wing, in the courtyard and outside the main building. Staff #4 went up to the independent building and entered the building, finding Tenant #1 inside. A tenant in the independent building let Tenant #1 in when he/she was found rattling the main entrance door. Staff #3 reported Tenant #1 was returned to the building after approximately 10 minutes of searching.

During interview, Staff #4 reported she was the only staff member on the west wing that had a pager on the evening of 3-21-13. Staff #7, CNA, also had a pager but she worked on the east wing on 3-21-13. There were no pagers available for Staff #3 and Staff #6.

Tenant #1 was wearing pants, a long sleeved shirt, socks and shoes. Tenant #1 did not have on a coat. It was unknown the exact amount of time Tenant #1 spent outside without supervision but was estimated to be approximately 10 minutes after Staff #4 notified the other staff that the alarm had sounded and she was unable to locate Tenant #1.

The state climatologist reported the weather at 8:00 p.m. on 3-21-13 was 26 degrees with winds from the northeast at 6 miles per hour, making the wind chill 19 degrees, with clear skies. Sunset was at 7:19 p.m.

The LPN completed a physical assessment of Tenant #1 following the elopement finding no injury.

The program's alarm system failed as not all staff members had a pager. The pager is utilized to notify staff members of the unauthorized exit by a cognitively impaired tenant. The audible alarm which also sounds at the door only sounds for 12 seconds then silences; therefore, if staff members are inside an apartment with the door closed, the audible alarm may not be heard readily. The batteries had died in the walkie; thereby, staff member communication was impeded. Staff response time was delayed by 8 minutes due to the lack of pagers and working walkies. Tenant #1 eloped from the program when the alarm system failed.

- 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. Program Reporting to the Department

- Monitoring Observation: Tenant #1's clinical record included a note, dated 1-17-13 at approximately 12:00 noon, documenting Tenant #1 followed a service delivery man out the front door. Staff followed and brought Tenant #1 back into the building after approximately seven minutes.

  According to the Incident Report, dated 1-17-13 at 12:00 noon, documented Tenant #1 and staff followed the delivery man out the building front door with staff members returning with Tenant #1 in approximately seven minutes.

  During interview, Staff #1, CNA, reported she worked the dayshift on 1-17-13. Staff #1 reported she worked on the east wing as a medication manager on 1-17-13 but went to the west wing for something around noon. Staff #8, activity assistant, stopped Staff #1 and told Staff #1 that she thought Tenant #1 went out through the west lobby door with a delivery man but didn't go after the tenant immediately. Staff #1 and Staff #8 went to the lobby but didn't find Tenant #1. Both staff members looked for Tenant #1, finding Tenant #1 outside at the end of the building on the sidewalk next to the buses and dumpsters.

  During interview, Staff #8, activity assistant, reported she worked the dayshift on 1-17-13. Around 12:00 noon, she was sitting in the common dining room area visiting with a group of tenants. Staff #8 reported she saw the delivery man go out the west lobby door. "Out of the corner of my eye" she saw Tenant #1 walk toward the west lobby door that the delivery man had gone out. No alarm sounded "so didn't respond right away. After it registered" one minute later, she told Staff #1 that she thought Tenant #1 followed the delivery man into the lobby. Both Staff #1 and Staff #8 went to the lobby and did not see Tenant #1. The lobby entrance was not sounding but both went outside. Tenant #1 was seen at the end of the building on the sidewalk next

to the buses and dumpsters. Tenant #1 was dressed in long pants, a shirt, shoes and socks. Tenant #1 did not have a coat on.

Written statements by involved staff members were found in the previous Director of Nursing's desk during the on-site visit by the monitor. The Quality Improvement Personnel Western Division presented the written statements. The statement completed by Staff #8 verified her interview as stated above. The statement indicated Staff #8 saw Tenant #1 walk toward the west lobby door about one minute after the delivery man exited the door. Staff #8 waited "a couple of minutes" waiting to see if an alarm sounded and it did not, so Staff #8 notified Staff #1 that she saw Tenant #1 go toward the door but did not hear an alarm. Both went to the lobby to see if Tenant #1 was in the lobby. The Tenant was not so they looked outside and saw Tenant #1 by the buses heading up the hill to the independent building.

Staff #8's personnel file contained documentation indicating Staff #8 was terminated from employment with the program the following day on 1-18-13; however, the file lacked a reason for the termination.

On 4-11-13 the Quality Improvement Personnel for the Western Division reported after she read the written statements found in the previous Director of Nursing's desk she believed the incident was an elopement and should have been reported to the Department of Inspections and Appeals.

The state climatologist reported the weather at 12:00 noon on 1-17-13 was 28 degrees with winds from the north at 12 miles per hour, making the wind chill 18 degrees, with clear skies.

Tenant #1 was wearing pants, a long sleeved shirt, socks and shoes. Tenant #1 did not have on a coat. It was unknown the exact amount of time Tenant #1 spent outside without supervision but was estimated to be approximately 7 minutes.

The previous Director of Nursing completed a physical assessment of Tenant #1 following the elopement finding no injury.

Staff members did not know the whereabouts of Tenant #1. Tenant #1 was outside the program without staff supervision. Tenant #1 eloped from the program. The program did not report the elopement to the Department of Inspections and Appeals as required by regulation.

During interview, Staff #3, CNA, reported on 2-11-13, Staff #9, Director of Operations of Legacy Pointe (the associated assisted living), brought Tenant #1 into the west wing at approximately 5:35 p.m. Staff #9 reported he found Tenant #1 outside the building down by the dumpsters unattended by staff members. Staff #3 reported she had not known Tenant #1 was out of the west wing. Staff #3 reported contacting the nurse on-call and the previous Director of Nursing immediately after Staff #9 returned Tenant #1 to the building. Staff #3 reported the following day she was questioned further by the previous Director of Nursing and was told it was all taken care of.

During interview, Staff #5, CNA, reported on 2-11-13, Staff #9 brought Tenant #1 into the west wing at approximately 5:35 p.m. Staff #9 reported he found Tenant #1 outside the building down by the dumpsters unattended by staff members. Staff #5 reported she had not known Tenant #1 was out of the west wing. Staff #5 reported she had heard the lobby entrance alarm around 5:15 p.m. She went immediately to the lobby and saw a mailman in the lobby. The mailman requested the location of another building. Staff #5 gave directions to the mailman and reset the alarm. Staff #5 did not see Tenant #1 in the lobby area. The alarm on the west lobby door did not sound. "That night I was told that the east and west wing lobby doors could be opened from the inside without setting off the alarm if someone was standing on the other side of the door" triggering the motion sensor to disengage the alarms. Staff #5 reported she wrote a note about the alarms disengaging inappropriately and left it in the previous Director of Nursing's mailbox.

The program's alarm details showed the lobby door alarm sounded at 5:13 p.m. and was cleared at 5:15 p.m.

Staff #9 reported he was leaving from the Legacy Pointe assisted living building at approximately 5:30 p.m. when he was summoned by telephone to the Legacy Gardens building to fix a computer problem. Staff #9 reported it took approximately 5 minutes to fix the computer problem. When leaving the building, Staff #9 observed Tenant #1 walking on the sidewalk toward the front door of the Gardens building. Tenant #1 was located at the end of the building by the dumpsters and appeared to be returning to the program. Staff #9 took Tenant #1 back to the west wing where staff members had not realized he/she was missing. Staff #9 reported he contacted the previous Director of Nursing and the previous Executive Director to report the incident. He reported being told that the previous Director of Nursing and the previous Executive Director would take care of it and he was to "step back".

The state climatologist reported the weather at 5:30 p.m. on 2-11-13 was 31 degrees with winds from the west at 15 miles per hour with gusts up to 25 miles per hour, making the wind chill 20 degrees, with cloudy skies. Sunset was at 5:35 p.m.

Tenant #1 was wearing pants, a long sleeved shirt, socks and shoes. Tenant #1 did not have on a coat. It was unknown the exact amount of time Tenant #1 spent outside without supervision.

The program did not have documentation of a physical assessment of Tenant #1 by a nurse following the elopement.

Staff members did not know the whereabouts of Tenant #1. Tenant #1 was outside the program without staff supervision. Tenant #1 eloped from the program. The program did not report the elopement to the Department of Inspections and Appeals as required by regulation.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program. (IAC r. 481-67.4(4))

C. Criteria for Admission and Retention

Complaint/Incident Allegation: The program reported a tenant eloped from the building unaccompanied by staff members, resulting in staff member unawareness of the whereabouts of the tenant for an extended period of time.

- Monitoring Observation: The program reported five tenants, Tenants #1, #2, #3, #4 and #5, wandered throughout the secured memory care units. Tenants #2, #3, #4 and #5 at times would exit seek but had never eloped from the program. Tenant #1 frequently exited the west wing door into the lobby and frequently exited the courtyard doors, setting off the alarm system. Tenant #1 exhibited exit seeking behaviors and repeatedly pushed on the egress bars of the lobby exit door, exiting into the open neighborhood if not responded to immediately by staff members.

  During interview, Staff #1 and Staff #8, both CNAs, reported Tenant #1 exited the building without staff knowledge. Staff #1 reported she worked on the east wing as a medication manager on 1-17-13 but went to the west wing for something around noon. Staff #8, activity assistant, stopped Staff #1 and told Staff #1 that she thought Tenant #1 went out through the west lobby door with a delivery man but didn't go after the tenant immediately. Staff #1 and Staff #8 went to the lobby but didn't find Tenant #1. Both staff members looked for Tenant #1, finding Tenant #1 outside at the end of the building on the sidewalk next to the buses and dumpsters.

  Staff #8, activity assistant, reported she worked the dayshift on 1-17-13. Around 12:00 noon, she was sitting in the common dining room area visiting with a group of tenants. Staff #8 reported she saw the delivery man go out the west lobby door. "Out of the corner of her eye" she saw Tenant #1 walk toward the west lobby door that the delivery man had gone out. No alarm sounded "so didn't respond right away. "After it registered" one minute later, she told Staff #1 that she thought Tenant #1 followed the delivery man into the lobby. Both Staff #1 and Staff #8 went to the lobby and did not see Tenant #1. The lobby entrance was not sounding but both went outside. Tenant #1 was seen at the end of the building on the sidewalk next to the buses and dumpsters. Tenant #1 was dressed in long pants, a shirt, shows and socks. Tenant #1 did not have a coat on.

  The state climatologist reported the weather at 12:00 noon on 1-17-13 was 28 degrees with winds from the north at 12 miles per hour, making the wind chill 18 degrees, with clear skies.

  Tenant #1 was wearing pants, a long sleeved shirt, socks and shoes. Tenant #1 did not have on a coat. It was unknown the exact amount of time Tenant #1 spent outside without supervision but was estimated to be about 7 minutes.

  The previous Director of Nursing completed a physical assessment of Tenant #1 following the elopement finding no injury.

  The nurse review, dated 1-18-13, documented Tenant #1 had been increasingly aggressive towards staff when they tried to redirect his/her from going out of doors. The review noted Tenant #1 had been increasingly adamant about going out both the

unit door and "especially the front door". Tenant #1 had been witnessed swinging at staff members attempting to hit and had made contact a few times. The physician ordered Trazadone 25 milligrams (mg) twice daily. Tenant #1 saw the physician on 1-21-13 and the physician increased Trazadone from 25 mg twice daily to 25 mg in the morning and 50 mg in the afternoon.

The clinical note, dated 2-5-13, indicated staff members had given Tenant #1 Ativan on an as needed basis 15 times between 1-22-13 and 2-2-13 due to difficult redirection and aggression.

The clinical note, dated 2-6-13, indicated staff members found Tenant #1 in his/her bathroom. Tenant #1 had a bowel movement and had been "playing in it". Tenant #1 had feces on the hands and face and appeared to be eating the feces as feces was found in Tenant #1's mouth. Staff members notified the physician who ordered a geri-psychiatric evaluation on 2-7-13. Tenant #1's legal representative was notified and told of the geri-psychiatric evaluation. The legal representative was to set up the appointment time and let the program know of the time so transportation could be set up.

During interview, Staff #3, CNA, reported on 2-11-13, Staff #9, Director of Operations of Legacy Pointe (the associated assisted living), brought Tenant #1 into the west wing at approximately 5:35 p.m. Staff #9 reported he found Tenant #1 outside the building down by the dumpsters unattended by staff members. Staff #3 reported she had not known Tenant #1 was out of the west wing. Staff #3 reported contacting the nurse on-call and the previous Director of Nursing immediately after Staff #9 returned Tenant #1 to the building. Staff #3 reported the following day she was questioned further by the previous Director of Nursing and was told it was all taken care of.

During interview, Staff #5, CNA, reported on 2-11-13, Staff #9 brought Tenant #1 into the west wing at approximately 5:35 p.m. Staff #9 reported he found Tenant #1 outside the building down by the dumpsters unattended by staff members. Staff #5 reported she had not known Tenant #1 was out of the west wing. Staff #5 reported she had heard the lobby entrance alarm around 5:15 p.m. She went immediately to the lobby and saw a mailman in the lobby. The mailman requested the location of another building. Staff #5 gave directions to the mailman and reset the alarm. Staff #5 did not see Tenant #1 in the lobby area. The alarm on the west lobby door did not sound. "That night I was told that the east and west wing lobby doors could be opened from the inside without setting off the alarm if someone was standing on the other side of the door" triggering the motion sensor to disengage the alarms. Staff #5 reported she wrote a note about the alarms disengaging inappropriately and left the in the previous Director of Nursing's mailbox.

The program's alarm details showed the lobby door alarm sounded at 5:13 p.m. and was cleared at 5:15 p.m.

Staff #9 reported he was leaving from the Legacy Pointe assisted living building at approximately 5:30 p.m. when he was summoned by telephone to the Legacy Gardens building to fix a computer problem. Staff #9 reported it took approximately 5 minutes to fix the computer problem. When leaving the building, Staff #9 observed

Tenant #1 walking on the sidewalk toward the front door of the Gardens building. Tenant #1 was located at the end of the building by the dumpsters and appeared to be returning to the program. Staff #9 took Tenant #1 back to the west wing where staff members had not realized he/she was missing. Staff #9 reported he contacted the previous Director of Nursing and the previous Executive Director to report the incident. He reported being told that the previous Director of Nursing and the previous Executive Director would take care of it and he was to "step back".

Tenant #1 was wearing pants, a long sleeved shirt, socks and shoes. Tenant #1 did not have a coat on. It was unknown how long Tenant #1 was outside unsupervised.

The state climatologist reported the weather at 5:30 p.m. on 2-11-13 was 31 degrees with winds from the west at 15 miles per hour with gusts up to 25 miles per hour, making the wind chill 20 degrees, with cloudy skies. Sunset was at 5:35 p.m.

The program did not have documentation of a physical assessment of Tenant #1 by a nurse following the elopement

The clinical note, dated 3-1-13, documented Tenant #1 had been more agitated lately, more aggressive and very focused on eloping from the program. The physician was notified and increased the Trazadone to 50 mg twice daily.

The clinical note, dated 3-15-13, documented the previous Director of Nursing called Tenant #1's legal representative to check on the geri-psychiatric evaluation date. The legal representative reported cancelling the evaluation as the legal representative did not believe Tenant #1 needed it.

The clinical note, dated 3-19-13, documented the previous Director of Nursing rescheduled the appointment for Tenant #1's geri-psychiatric evaluation for July 23, 2013.

The clinical note, dated 3-21-13, documented at approximately 8:00 p.m., Tenant #1 exited the west lobby doors and the main entrance of the lobby, entered the open neighborhood without staff member supervision.

According to the program's alarm detail, the first alarm connected to the west lobby door sounded at 7:59 p.m., the second alarm connected to the main entrance of the building located in the lobby sounded at 8:00 p.m. Staff members did not respond to the alarm until 8:07 p.m., allowing Tenant #1 to exit the building and leave the immediate premises.

During interview, Staff #4, CNA, reported she worked on the west wing and was giving a shower to another tenant with the doors closed on 3-21-13 at 7:00 p.m. Staff #4 reported her pager alarm went off at 7:59 p.m. and again at 8:00 p.m. Staff #4 assumed the other staff members working on the west wing would respond to the alarm. After noting no response after a few minutes, Staff #4 quickly assured the tenant receiving the shower was safe and then went to respond to the alarm. Staff #4 reported she did not have a portable walkie with her as the battery had died earlier in the night.

During interview, Staff #3, NA, reported she passed medications on the east wing and floated over to the west wing when assistance was needed on 3-21-13. Staff #3 reported she went to the west wing at approximately 7:50 p.m. and found no staff members in the common areas. Staff #3 searched all hallways for staff finding Staff #6, LPN, exiting another tenant's room. Staff #3 reported another tenant coming down the hall asked for assistance so Staff #3 went with the tenant to his/her room to prepare for bed. During the care, Staff #3 reported needing gloves so she exited the apartment and went to the medication cart for gloves. Staff #4 came running down the hallway asking where Tenant #1 was as the alarms had sounded. Staff #6 denied hearing any audible alarm sounding. Staff #3 and Staff #6 did not have pagers on as there were not enough available for all staff members to have while on duty. Staff #6 shut the alarms off at 8:07 p.m. Staff #3, #4 and #6 looked throughout the building, in the east wing, in the courtyard and outside the main building. Staff #4 went up to the independent building and entered the building, finding Tenant #1 inside. A tenant in the independent building let Tenant #1 in when he/she was found rattling the main entrance door. Staff #3 reported Tenant #1 was returned to the building after approximately 10 minutes of searching.

During interview, Staff #4 reported she was the only staff member on the west wing that had a pager on the evening of 3-21-13. Staff #7, CNA, also had a pager but she worked on the east wing on 3-21-13. There were no pagers available for Staff #3 and Staff #6.

Tenant #1 was wearing pants, a long sleeved shirt, socks and shoes. Tenant #1 did not have on a coat. It was unknown the exact amount of time Tenant #1 spent outside without supervision but was estimated to be approximately 10 minutes after Staff #4 notified the other staff that the alarm had sounded and she was unable to locate Tenant #1.

The state climatologist reported the weather at 8:00 p.m. on 3-21-13 was 26 degrees with winds from the northeast at 6 miles per hour, making the wind chill 19 degrees, with clear skies. Sunset was at 7:19 p.m.

The LPN completed a physical assessment of Tenant #1 following the elopement finding no injury.

On 4-3-13, the program issued a 30 day notice for termination of services to Tenant #1's legal representative, citing the aggressive behaviors and elopement attempts as reason for the involuntary discharge.

Tenant #1 exhibited continued chronic elopement attempts despite intervention. Tenant #1 exhibited aggressive behavior toward staff members and exhibited an episode of playing in his/her feces, attempting to eat the feces. The program did not follow up to assure Tenant #1 received the physician ordered Geri-psychiatric evaluation. Tenant #1 exceeded the level of care acceptable for an assisted living program. The program did not give a 30 day notice for termination of services until 4-3-13 despite Tenant #1's continued elopement attempts and aggressive/inappropriate behaviors.

- 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: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression. (IAC r. 481-69.23(1))

D. Tenant Documents

During the on-site visit, the following was identified:

- Monitoring Observation: During interview, Staff #3, CNA, reported on 2-11-13, Staff #9, Director of Operations of Legacy Pointe (the associated assisted living), brought Tenant #1 into the west wing at approximately 5:35 p.m. Staff #9 reported he found Tenant #1 outside the building down by the dumpsters unattended by staff members. Staff #3 reported she had not known Tenant #1 was out of the west wing. Staff #3 reported contacting the nurse on-call and the previous Director of Nursing immediately after Staff #9 returned Tenant #1 to the building. Staff #3 reported the following day she was questioned further by the previous Director of Nursing and was told it was all taken care of.

  During interview, Staff #5, CNA, reported on 2-11-13, Staff #9 brought Tenant #1 into the west wing at approximately 5:35 p.m. Staff #9 reported he found Tenant #1 outside the building down by the dumpsters unattended by staff members. Staff #5 reported she had not known Tenant #1 was out of the west wing. Staff #5 reported she had heard the lobby entrance alarm around 5:15 p.m. She went immediately to the lobby and saw a mailman in the lobby. The mailman requested the location of another building. Staff #5 gave directions to the mailman and reset the alarm. Staff #5 did not see Tenant #1 in the lobby area. The alarm on the west lobby door did not sound. "That night I was told that the east and west wing lobby doors could be opened from the inside without setting off the alarm if someone was standing on the other side of the door" triggering the motion sensor to disengage the alarms. Staff #5 reported she wrote a note about the alarms disengaging inappropriately and left the in the previous Director of Nursing's mailbox.

  The program's alarm details showed the lobby door alarm sounded at 5:13 p.m. and was cleared at 5:15 p.m.

  Staff #9 reported he was leaving from the Legacy Pointe assisted living building at approximately 5:30 p.m. when he was summoned by telephone to the Legacy Gardens building to fix a computer problem. Staff #9 reported it took approximately 5 minutes to fix the computer problem. When leaving the building, Staff #9 observed Tenant #1 walking on the sidewalk toward the front door of the Gardens building. Tenant #1 was located at the end of the building by the dumpsters and appeared to be returning to the program. Staff #9 took Tenant #1 back to the west wing where staff members had not realized he/she was missing. Staff #9 reported he contacted the previous Director of Nursing and the previous Executive Director to report the incident. He reported being told that the previous Director of Nursing and the previous Executive Director would take care of it and he was to "step back".

Tenant #1's clinical record did not include any documentation of the 2-11-13 incident. The program did not have documentation of an incident report upon arrival of the monitor. The Director of Operations for Legacy Pointe Assisted Living completed an incident report on 4-10-13 after the monitor had begun investigating the elopement incident. The Director of Operations reported he had never been asked to complete an incident report until 4-10-13.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: (i) when any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; and (o) incident reports involving the tenant, 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). (IAC r. 481.69.25(1)i and o.)