Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: October 17, 2019
Program Name: Senior Star at Elmore Place Memory Care
Address: 4504 Elmore Avenue Davenport, IA 52807
Type of Action: incident #85523
Date(s) of Action: 9/11/19 to 9/26/19

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. Based on observation, interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate for 1 of 1 tenants identified in Incident 85523 (Tenant #1). Findings follow: 1. Review of an incident report dated 7-31-19 revealed Tenant #1 was found deceased in her apartment on 7-31-19 at 10:00 a.m. Her feet were entangled in the sheets with her neck resting on the U bar attached to her bed. The autopsy report completed on 8/1/19 revealed the tenant died from positional asphyxia. The position the decedent was found in placed significant weight and pressure on her neck in relation to the bed rail. Review of Tenant #1's file revealed diagnoses including major neurocognitive disorder, hypertension, insomnia, chronic back pain, recurrent falls and dementia of Alzheimer type with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale at the time of the incident, which indicated severe cognitive decline. A Change in Condition document dated 6-17-19 reflected Tenant #1 had been discharged from hospice. The hospital bed was removed from her apartment and a "regular bed" was brought in. A U bar had been placed on the bed to help with repositioning. Memory care staff were to ensure it was in the correct position at all times. Tenant #1's service plan dated 6-17-19 reflected a history of frequent falls. The interventions in place were unsuccessful; however, staff were to provide redirection and supervision to minimize falls. Due to "significant cognitive deficits" she was unable to understand her risk taking behaviors. Staff were to ensure Tenant #1's door was open at all times for frequent supervision while in her apartment. If Tenant #1 slept late staff were to check on her frequently and, once awake, assist her with getting up for the day promptly to minimize falls in her room. The service plan reflected when Tenant #1 went to bed she typically slept through the night without waking. Tenant #1 had a U bar placed on the bed to aid in positioning. Memory care staff were to ensure the U bar was in the correct position at all times. Staff provided toileting assistance twice per night and every two hours during the	**$10,000.00 total**

	day. 2. When interviewed on 9-11-19 at 5:42 p.m. and 9-16-19 at 2:23 p.m. Nurse #1, previously the Director of Nursing (DON), indicated Tenant #1 was discharged from hospice services in June. When on hospice Tenant #1 had a hospital bed with a half rail she used at times. When hospice was discontinued, the hospital bed was replaced with a twin bed. The U bar was added, as it was a good transition. The U bar was placed on the side of the bed nearest to the bathroom. Staff B (Nurse Manager at the time) put the U bar on the tenant's bed. Nurse #1 believed the U bar was donated from another tenant. Nurse #1 did not observe placement of the U bar. When interviewed on 9-16-19 at 9:56 a.m. and on 9-18-19 at 1:32 p.m. Nurse #2 revealed at the time of the incident she was the DON in the Assisted Living Program (AL) and was currently the DON for the Assisted Living Program for People with Dementia (ALP/D). She stated she did not develop Tenant #1's service plan but confirmed it stated memory care staff were to check placement of the U bar. She assumed it meant front line staff and said checking for correct placement was most likely not done. Direct care staff did not receive any training on the U bar. Nurse #2 revealed she was not made aware of the policy regarding bedside positioning bars until after the fact. The service plan reflected the bed rail and the restraint policy was followed. Staff A's Incident Witness Statement indicated on 7-31-19 between 10:00 a.m. and 10:15 a.m. she went to Tenant #1's apartment to get her ready for the day and saw her on the floor with her neck on the bar. She immediately radioed for a nurse. When interviewed on 9-17-19 at 10:32 a.m. and 1:41 p.m. Staff A stated she checked on Tenant #1 at approximately 6:45 a.m. and she was lying in bed on her back sleeping. Tenant #1's door was closed which was usual due to wandering tenants. Between 10:00 a.m. and 10:15 a.m. Staff A went to the apartment, turned on the light and observed the tenant from the back. Her neck was on the bar and her arms were out to the side. She called for help and staff responded. She didn't notice anything unusual about the placements of the U bar; however, she did not pay attention to it. On 9-18-19 at 10:45 a.m. Staff C said Tenant #1 had scheduled checks a couple of times per shift on third shift. On the night before the incident, she believed Tenant #1 slept through the night. She checked her to see if she was incontinent. One time she was incontinent and was changed in bed. When Tenant #1 was asleep her apartment door was closed. She did not observe the position of the bar and the bar was not touched on third shift. On 9-18-19 at 9:48 a.m. Staff D revealed certified nursing assistants did not check the placement of any bed rails utilized by tenants. Staff D had not observed the bed rail on Tenant #1's bed. She recalled Tenant #1's door being closed that morning when she walked by to get towels.	

	When interviewed on 9-18-19 at 1:00 p.m. Staff E revealed she was by the dining room when Staff A called for help in Tenant #1's apartment. She responded and observed Tenant #1 face down on the U bar. Staff E was not familiar with the tenant as she normally worked in the other program on campus (assisted living). She occasionally assisted in this program (memory care). She had never checked the placement of bars. When interviewed on 9-17-19 at 11:50 a.m. Staff F revealed she did not usually make beds and had never checked the placement of the U bar on Tenant #1's bed. Tenant #1's apartment door was usually closed as other tenants wandered. If Tenant #1 was resting staff were to check on her and let her rest. On 9-18-19 at 1:57 p.m. Staff G stated she couldn't speak for other staff, but if she noticed a U bar pulled out on a bed, she pushed it back in. She had not noted any issues with Tenant #1's bar. When interviewed on 9-18-19 at 1:46 p.m. Staff H revealed Tenant #1's apartment door was closed at night due to wandering tenants; however, if lying in bed during the day the door was kept open. Staff H had not observed a bed positioning bar; however, if there was as issue it would be reported to the nurse. 3. In summary, when discharged from hospice services the tenant's hospital bed was replaced by a twin bed with an attached U bar. The tenant's service plan indicated staff were to check for correct placement of the U bar. Interviews confirmed staff did not check U bars for correct placement and Nurse #2 indicated staff were not trained on U bar placement. The service plan stated the tenant's door was to remain open at all times in order to provide frequent supervision. Staff present at the time of the incident confirmed the door was shut that morning and in fact was often shut at night due to wandering behaviors of other tenants. In addition, Tenant #1 did not receive appropriate services related to the installation of the U bar on her bed. Please refer to the regulatory insufficiency related to Structural Requirements/Safety for further details.	
69.35(1)b	481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. Based on observation, interview and record review the Program failed to maintain a building that was safe regarding the placement and installation of assistive bed positioning bars for 1 of 1 tenants identified in Incident #85523 (Tenant #1). Findings follow: 1. Review of an incident report dated 7-31-19 revealed Tenant #1 was found deceased in her apartment on 7-31-19 at 10:00 a.m. Her feet were entangled in the sheets with her neck resting on the U bar attached to her bed. The report indicated the nurse on shift/on-call was	

	involved and 911 was called. The main office, Tenant #1's responsible party and the police department were notified. The incident type was indicated as death with an injury. Review of the autopsy report completed on 8/1/19 revealed the tenant died from positional asphyxia. The position the tenant was found in placed significant weight and pressure on her neck in relation to the bed rail. The report indicated "the decedent was found face down with her neck apparently stuck on black bed rail which was not a part of the original bed. In addition, it was noted that her legs were wrapped and intertwined with the bed sheets and blankets. Apparently, the blankets were tucked tightly into the corners of the bed. The patient was last seen alive approximately two hours prior at 0800 am when staff saw her sleeping in bed and decided to let her sleep a little longer." Review of Tenant #1's file revealed diagnoses including major neurocognitive disorder, hypertension, insomnia, chronic back pain, recurrent falls and dementia of Alzheimer type with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale at the time of the incident, which indicated severe cognitive decline. A Change in Condition document dated 6-17-19 reflected Tenant #1 had been discharged from hospice. The hospital bed was removed from her apartment and a "regular bed" was brought in. A U bar had been placed on the bed to help with repositioning. Memory care staff were to ensure it was in the correct position at all times. 2. When interviewed on 9-11-19 at 5:42 p.m. and 9-16-19 at 2:23 p.m. Nurse #1, previously the Director of Nursing (DON), indicated Tenant #1 was discharged from hospice services in June. When on hospice Tenant #1 had a hospital bed with a half rail she had used at times. When hospice was discontinued, the hospital bed was replaced with a twin bed. The U bar was added, as it was a good transition. The U bar was placed on the side of the bed nearest to the bathroom. Staff B (Nurse Manager at the time) put the U bar on the tenant's bed. Nurse #1 believed the U bar was donated from another tenant. Nurse #1 did not observe placement of the U bar. Nurse #2's typed statement indicated on 7-31-19 she was asked to come to Tenant #1's apartment by Staff A. When she entered the apartment she observed Tenant #1's neck was resting on the U bar, which was partially pulled out from the bed and her feet were wrapped up in the blankets. She immediately asked staff to leave the apartment and called for Health Services Administrator to come to the apartment and then called medics. After the medics and medical examiner left, the Health Services Administrator and Nurse #2 entered Tenant #1's apartment to check the placement and type of the U bar. It was noted the U bar was not properly leveled and had no strap. When interviewed on 9-16-19 at 9:56 a.m. and on 9-18-19 at 1:32 p.m. Nurse #2 revealed at the time of the incident she was the DON in the Assisted Living Program (AL) and was currently the DON for the Assisted Living Program for People with Dementia (ALP/D). Staff A	

	radioed for assistance to Tenant #1's apartment. She immediately responded to Tenant #1's apartment and observed Tenant #1 with her neck resting on the U bar. Her feet were wrapped up in blankets on the floor and her arms were dangling down. Tenant #1 was deceased when observed and the U bar was pulled out from the mattress. The bar was out far enough the tenant's head was resting on it. Nurse #2 indicated after the medical examiner moved Tenant #1's body, she observed a laceration on her neck. It appeared as if she tried to get up but her feet were tangled in the blankets and she fell. There was blood on the side where the neck was resting. Tenant #1's face was not against the bed. The police and medical examiner thought she rolled and suffocated; however, they possibly misunderstood that she was not bed bound and could get up and move on her own. She noted the U bar was not level, the feet of the bar were not touching the floor, and neither black stopper was on the floor. There were also no straps attached to the bar. She said Staff B had placed the bar on the bed for repositioning due to falls and weakness. Nurse #2 did not think she had ever installed a U bar without straps secured to the frame. When it was leveled it was normally very secure. (Tenant #1's U bar had been thrown away; however, Nurse #2 was shown a picture of the bed repositioning bar that the Program had provided and she said it was similar to the bar shown). The Health Services Administrator typed statement indicated on 7-31-19 she was called to the Program by Nurse #2 due to Tenant #1 being found on the floor deceased. After the investigators and the medical examiner left she went to the tenants' apartments that had U bars to ensure proper placement and security. When interviewed on 9-17-19 at 11:42 a.m., 9-16-19 at approximately 12:30 p.m. and 9-18-19 at 12:14 p.m. the Health Services Administrator revealed she was the Interim DON in memory care as Nurse #1 was on leave. On 7-31-19 around 10:00 a.m. she was notified by staff that Nurse #2 was trying to reach her. When she arrived at Tenant #1's apartment she observed Tenant #1 with her feet tangled in the bed sheets and her neck was resting on the U bar with her hands at her side. The U bar was still under the mattress and was pushed out some. She was not sure how far it was pushed out. After the investigators were done she and Nurse #2 went to the apartment. The medical examiner said Tenant #1 rolled out of bed and she disagreed due to Tenant #1's foot placement. She thought Tenant #1 went to stand up, her feet were tangled and she fell forward. Nurse #2 had mentioned the foot posts were not level. When the Health Services Administrator observed the U bar she noted the strap was not in place (it had been pointed out from investigators) and it was not level with the ground. She stated if the bar isn't level it is not as sturdy when pushed down. Tenant #1 had a twin size bed with box springs and mattress, which belonged to the Program. She had been told by Nurse #1 the U bar was provided by the Program and Staff B installed it on the bed. At times there was extra equipment stored in the Assisted Living. Direct care staff did not place bars on beds, only licensed personnel did. When interviewed on 9-16-19 at 10:38 a.m. the Executive Director	

	said he was alerted to the incident with Tenant #1. He went into Tenant #1's apartment and observed her on the floor. Her head was postured on the bar and the rest of her body was on the floor. The bar had pulled away from the bed, perhaps a foot or so. He did not look at the exact position. He was told Tenant #1's bar was not secured to the bed and straps were not utilized. The Program took immediate action and ordered Halo bars for the tenants with the bars. On 9-16-19 at 1:57 p.m. the Environmental Services Director said he had been walking in the lobby when the Executive Director said he was on his way to a death in memory care. He went to Tenant #1's apartment and secured it as it was an unexpected death. When he was in the apartment he noted the bar was pulled out from the bed 16 to 18 inches. He did not know where the bar came from. Environmental staff generally did not install medical equipment. On 9-17-19 at 4:05 p.m. Staff B said she currently worked as a floor nurse on an as-needed basis. She had been the Nurse Manager until 7-1-19. When Tenant #1 graduated from hospice in June the hospital bed was replaced by a twin bed. She recalled the hospital bed had one side rail on it. She wasn't positive but thought the twin bed may have had a U bar attached. If there was a bar put on it would have been at the direction of the DON. She denied changing out the bed or placing the U bar on the twin bed for Tenant #1. She noted there were extra U bars stored and utilized by the Program. She recalled she had been verbally trained on how to apply bars to beds and had done so during the time she was Nurse Manager. There were different types of bars available, some of which slid under the mattress and used straps. She was aware Tenant #1 had passed away but was provided vague details. When interviewed on 9-18-19 at 12:36 p.m. Staff I (maintenance) said sometimes work orders were generated to set up beds, and other times there were no work orders. Maintenance staff installed bed rails at times if there were a lot of pieces to deal with. If it slipped under the mattress nursing might do it. Staff I said he had not put many beds together in memory care when asked about Tenant #1's bed and the positioning bar. When interviewed on 9-19-19 at 1:03 p.m. Staff J (maintenance) said beds were stored in the garage in independent living and maintenance would set them up. Housekeeping might help. The bed positioning bars that slipped under the bed were installed by nursing. Maintenance staff installed the Halo bars as they were kind of complicated to put together. Staff J did not have any knowledge of the equipment for Tenant #1. 3. The bar installed on Tenant #1's bed was not available for observation as it had been discarded by the Program. The Health Services Administrator provided an online picture of a bed positioning bar similar to the bed positioning bar used in Tenant #1's apartment. The manufacture's User Guide for that bar included assembly instructions, general warnings and warranty information.	

	Assembly instructions included: - Assemble the brace bar to the two support frame pieces. Ensure the arrow on the two support frame pieces is pointing up. - Attached the base frame to the support frame pieces. - Attach the legs to the support frame pieces. - Attach the assist bar to the other side of the support frame pieces. The clips on the assist bar should face outward (storage packet hangs on). - Attach the storage pocket to assist bar (outside). - Remove the mattress from the bed. Put the assembled bed assist at location on the bed, the bed assist would sit between the bed frame and mattress or between the box spring and the mattress. The legs would be need be adjusted dependent on the height of the bed frame. Make sure the legs are firmly touching the ground. When in place thread the strap through two loops on the base (dependent on the size of the bed might reach only one loop), - Secure the strap around the bed frame on the opposite side of the bed and tighten. - Put the mattress back on the bed and the top of the assist bar could need a height adjustment dependent on the width of the mattress. General warnings indicated: - Before use ensure that all push buttons and clips are securely in place and that the legs are leveled and are securely touching the ground." - The unit is not meant to support full body weight but to assist with stability when getting in or out of bed. - The unit is not meant to be used as a restraint for preventing people from rolling out of bed. A video tutorial of the product was observed on 9-12-19 (the date the video was posted was 6-21-14). The video tutorial indicated the bed assist bar could be used for a home care mattress/framework or a residential bed. The individual demonstrated the assembly of the product. It was then indicated the bar would be slid between the mattress and box springs, which should hold into place without problem. However, if there was a very light individual, if wanted, although not necessary, straps could be used. It was then demonstrated how the straps would be applied. To ensure it was properly set up, while sitting on the bed, grab a hold of the bar, and it should not flex away or out from the bed. It referred to the owner's manual or tech support desk for questions. A Monthly V/S (vital signs) and Weight document indicated Tenant #1's weight in June 2019 was 97.8 and 101 in July 2019. 4. In summary, when Tenant #1 was discharged from hospice her hospital bed was replaced with a twin bed with an attached U bar both provided by the Program. It could not be determined who attached the U bar to the bed. When Tenant #1 was found deceased in her apartment on 7-31-19 with her neck on the U bar, the U bar was not secured with a strap and was not leveled. The bar on Tenant #1's bed	

	was discarded by the Program; however, an online picture of a similar bar was provided by the Program. The bar provided by the Program was not installed per owner's manual instructions regarding the placement of the strap and the leveling of the bar.	