IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

July 27, 2009

Incident #23662-I
#23666-I
#23665-I
#23748-I

Christina Bricker, Housing Director
Summit Pointe Senior Living Community
3505 English Glen Avenue
Marion, IA 52302-4711

RE: Final Incident Investigation Report, Summit Pointe Senior Living Community, Marion, IA

Dear Ms. Bricker:

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program:

Christina Bricker, Housing Director
Summit Pointe Senior Living Community
3505 English Glen Avenue
Marion, IA 52302-4711

Incident Intake #: 23662-I
23666-I
23665-I
23748-I

Date of Incident Investigation:

June 15 & 16, 2009

Monitor(s):

Vickie Clingan, RN MA
Stephanie Cummins, MA

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Summit Pointe Senior Living Community on June 15 & 16, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	96
Current number of tenants with cognitive disorder:	4
Total Population of GPP:	100

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	11
Total Census of ALP:	111

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There have been no Regulatory Insufficiencies this certification period.

Incident Investigation – The investigator(s) made the observations detailed in the following areas.

A. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Incident Allegation #23662-I: The program reported Tenant #1 fell and was found on the floor in his/her apartment by the tenant's family member. The tenant was sent to the emergency room (ER) and was found to have a fractured hip.

Monitoring Observation: Tenant #1, a 94 year old, was admitted on 4-22-09 and diagnoses include: Alzheimer's Disease, Hypertension (HTN) and Fractured Right Humerus. The tenant was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive impairment. According to the Resident Occurrence Report and Service Notes, staff was called to the tenant's apartment on 5-27-09. When staff arrived, the tenant was sitting in a wheelchair and a family member was with the tenant. The tenant reported falling and was on the floor when the family member arrived. The family member picked the tenant up and put him/her in the wheelchair, prior to staff arriving. The tenant reported pain in his/her left leg and staff asked if the tenant wanted to go to the hospital and the tenant refused. The tenant was unable to bear weight on the left leg and was laid in bed. The family member then requested the tenant go to the hospital because he/she was unable to lift the left leg and the ambulance was called. At the time of the on-site, the tenant's health had deteriorated and he/she had not returned to the program.

The tenant had falls or was found on the floor on 4-27-09 and 4-28-09 without injuries. The tenant received physical therapy (PT), which started on 4-26-09. Evaluations were completed appropriately. The service plan reflected a history of falls and PT.

Staff #1 was interviewed and indicated she responded to the call light and when she arrived the tenant was in the wheelchair and stated his/her knee/leg area hurt. Staff #1 stated the tenant needed to go to the hospital but the tenant refused. Staff #1 stated the tenant was wearing a pendant when the incident occurred; however, the tenant did not use it.

Incident Allegation #23666-I: The program reported Tenant #2 was yelling for assistance and found on the floor in his/her apartment. The tenant went to the hospital and was diagnosed with a fractured hip.

Monitoring Observation: Tenant #2, an 82 year old, was admitted on 4-15-09 and diagnoses include: Left Frontal Subdural Hematoma, Dementia - Lewy Body, Parkinson's Disease, Recent Left Knee Injury, Coronary Artery Disease (CAD), Chronic Kidney Disease, Central Sleep Apnea, HTN and Hyperlipidemia. The tenant was staged at a seven on the GDS, which indicated very severe cognitive decline. The tenant resided in the dementia unit and died on 6-11-09.

The tenant had been found on the floor next to the bed on 4-28-09 at 4:00 a.m. during hourly checks. The tenant denied any pain and did not have any apparent injuries at that

time. According to a Resident Occurrence Report form on 4-28-09 at 7:15 a.m. and Service Notes, staff heard the tenant yelling for help. When staff arrived, the tenant was lying on the floor on the left side and stated the left hip hurt. Staff placed a pillow under the tenant's head and covered the tenant with a blanket. Staff called an ambulance and hospice to notify them of the incident. The tenant was diagnosed with a broken hip, was hospitalized and then returned to the program. The tenant died on 6-11-09.

Evaluations and service plans were completed appropriately prior to the fall and post hospitalization. The service plan reflected interventions including: an alarm while in bed, a gait belt during transfers, staff checks, reminders to not shuffle when walking and how to approach the tenant.

Staff #2 was interviewed and reported the incident happened around shift change at approximately 7:00 a.m. Staff heard the tenant yelling and responded to the tenant. He/she had removed clothing, including the shirt which had the alarm attached to it. The tenant stated he/she was in pain and was touching the leg/hip area. Staff called the ambulance and the tenant was taken to the hospital.

Incident Allegation #23665-I: The Program reported Tenant #3 fell and hit his/her head causing an injury to the forehead and nose with head and neck pain. The tenant went to the ER and had a fractured neck.

Monitoring Observation: Tenant #3, an 85 year old, was admitted on 1-16-08 and diagnoses include: Angina Pectoris, History of Dementia and Short Term Memory Loss, Congestive Heart Failure (CHF), Hyperlipidemia, Atrial Fibrillation, Degenerative Joint Disease (DJD), Osteoporosis, Lower Extremity Edema, Hypothyroid, Glaucoma, Poor Vision, Hypothyroidism and Visual Migraines.

According to the Resident Occurrence Report dated 5-24-09 the tenant paged staff and staff found the tenant lying on his/her back in the living room. The tenant stated he/she had fallen and hit his/her head hard on the television. There was an abrasion to the tenant's upper central forehead and nose. The tenant complained of head and neck pain. The nurse was notified and advised staff to send the tenant to the ER for evaluation. The tenant was taken by ambulance. According to Service Notes, the tenant's family members reported the tenant had fractured his/her neck and was transferred to the University of Iowa Hospital. Surgery was estimated at seven hours and the tenant had a rib harvested in order to fuse the vertebra, C-1 and C-2 together. The tenant was transferred to a local hospital after surgery for rehabilitation. The tenant was at an acute rehabilitation unit at the time of the on-site.

The tenant's evaluations and service plans were completed appropriately.

Staff #3 was interviewed and stated the tenant pushed the pendant and she responded and found the tenant on his/her back in the living room. The tenant had an abrasion on his/her forehead, complained of pain on the front of the head and had crawled or scooted a small distance. The tenant asked Staff #3 to call family. Staff #3 did not move the tenant because he/she complained of pain and she called the nurse. The nurse instructed

staff to call 911. After the paramedics arrived, the tenant also began to complain of pain in the back of the head.

The tenant's family members were interviewed and stated they could not have been more pleased with how the situation was handled.

Incident Allegation #23748-I: The Program reported Tenant #4 was found on the floor by a family member. The tenant was transported to the hospital and was diagnosed with a hip fracture.

Monitoring Observation: Tenant #4, an 81 year old, was admitted on 3-2-07 and diagnoses include: Aortic Aneurysm, Parkinson's Disease, Mild Dementia, Gastroesophageal Reflux Disease (GERD) and Benign Prostate Hypertrophy (BPH). The tenant was staged at a four on the GDS, which indicated moderate cognitive impairment.

According to a Resident Occurrence Report, the tenant was found on the floor on 6-1-09. The tenant had gotten out of the chair and walked a couple of steps without stand by assistance or a walker. The tenant's family member was in the room and heard the tenant fall. The tenant was assessed by the nurse, had complaints of left rib pain and pain in the groin area and was sent to the ER for evaluation.

Evaluations and service plans were completed appropriately.

The Health Services Director stated the tenant fell and had pain in his/her left rib area. The tenant was checked and nothing appeared out of place. The tenant requested to go to the ER. The first report the program received from the hospital on 6-2-09 indicated nothing was broken. After the initial report, there was a follow up report on 6-3-09 stating the tenant had a fractured hip and was having surgery to repair the hip. The tenant was at a care center at the time of the on-site.

- Regulatory Insufficiency: None noted.

Dated this 27th day of July, 2009.