IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

July 28, 2009

Incident #23499-I

Jerry Bell, Manager
Sunset Park Place
3730 Pennsylvania Avenue
Dubuque, IA 52002-3780

RE: Final Incident Investigation Report, Sunset Park Place, Dubuque, IA

Dear Mr. Bell:

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: **Incident Intake #:** 23499-I

Jerry Bell, Manager
Sunset Park Place
3730 Pennsylvania Avenue
Dubuque, IA 52002-3780

Date of Incident Investigation:

July 7, 2009

Monitor(s):

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 Sunset Park Place on July 7, 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:	47
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	49

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

Total Population of DSP:	7
Total Census of ALP:	56

***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 substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plans, Food Service and Staffing.

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: It was reported by the program that a tenant was walking with his/her walker from the dining room to the living room and fell. The tenant suffered a laceration above the eye requiring five sutures, had a fractured humerus and a fractured femur.

Monitoring Observation: Tenant #1, a 90 year old, was admitted on 9-13-04 and diagnoses include: Pneumonia (3-14-09), Diabetes, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease (COPD), Status Post (S/P) Right Hip Fracture, S/P Left Hip Fracture, Gout, Carotid Stenosis, Depression, Deep Vein Thrombosis (DVT) and Congestive Heart Failure (CHF). The tenant was staged a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive impairment. The tenant resided in the dementia unit.

According to an Incident Report on 5-16-09 at 5:35 p.m., Tenant #1 was ambulating with his/her walker from the dining room to the living room and lost his/her balance, falling to the floor. According to the report, staff used the Emergency Response (ER) button to call for additional staff. Staff called 911, called the tenant's family member and called the Healthcare Coordinator. The report indicated staff kept the tenant in position on the floor, applied a cold compress to the laceration above the right eye and calmed the tenant. Emergency staff arrived and the tenant was taken to the emergency room (ER). The report indicated the tenant's reaction to the incident was concern regarding his/her eye glasses and walker being broken. According to Nurse's/Care Notes dated 5-17-09, the tenant had a laceration above the right eye that required five sutures, a Left Femur Fracture and a Right Humerus Fracture. The tenant had surgery to repair the Left Femur Fracture. According to Nurse's/Care Notes dated 6-18-09, the tenant transferred to a skilled level of care and has remained there.

The Incident Report Log was reviewed from 3-19-09 to the date of the fall on 5-16-09. The document showed only the fall on 5-16-09 for Tenant #1. A review of the tenant's Nurse's/Care Notes indicated the tenant did not have a recent history of falls.

According to a Resident Hourly Check document, hourly checks were completed on Tenant #1 consistently. The fall occurred at 5:35 p.m. and the last recorded check prior to the fall was documented at 5:00 p.m.

Staff #1 was interviewed and indicated she was working in the dementia unit at the time the tenant fell. She stated after Tenant #1 finished eating supper he/she was walking with the wheeled walker and she was with the tenant. She stated the tenant "miss-stepped" and went down very fast. She stated she used the emergency pendant and additional staff arrived quickly. She observed the tenant's left leg was swollen and was considerably shorter; the tenant complained of arm pain and had a laceration above the right eye. Staff #1 called 911, the tenant's family and the nurse. She held pressure above the tenant's

right eye due to the laceration; she did not move the tenant and stayed with the tenant at all times. The ambulance arrived and the tenant was transported to the hospital. The tenant did not have any other falls with injuries, according to the staff.

The Healthcare Coordinator was interviewed and she stated she was notified immediately regarding the fall and was pleased with how staff responded. She stated staff applied compresses, did not move the tenant, called 911, family and the nurse. According to the Healthcare Coordinator, the tenant went to the hospital and then to a higher level of care. The tenant had not returned to the program since the fall on 5-16-09.

Staff #1 and #2 and the Healthcare Coordinator did not identify any tenants that exceeded the appropriate level of care. A review of Tenant #1's file indicated he/she did not exceed the appropriate level of care. Evaluations and service plans were completed appropriately for the tenant.

Tenant #1's fall occurred on 5-16-09 at 5:35 p.m. The Healthcare Coordinator reported the fall with injury to the Department on 5-17-09 within the appropriate timeframe of 24 hours.

- Regulatory Insufficiency: None noted.

Dated this 28th day of July, 2009.