IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

April 21, 2010

Incident #27885-I

Joni L. Fahrenkrog, Manager
Grand Haven
201 E Franklin St
Eldridge, IA 52748-1311

RE: Final Incident Investigation Report, Grand Haven, Eldridge, IA

Dear Ms. Fahrenkrog:

Enclosed is the **Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and 481 Iowa Administrative Code (IAC), chapters 67 & 69. **No Regulatory Insufficiencies were identified.** There is no further action needed by the program.

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

Sincerely,

Chris Nothaft

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 #: 27885-I**

Joni Fahrenkrog, Manager
Grand Haven
201 E Franklin St
Eldridge, IA 52748-1311

Date of Incident Investigation:

April 12, 2010

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. 481 IAC r. 67.10(5). 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 481 IAC - chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Grand Haven on April 12, 2010. 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:	66
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	68

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

Total Population of DSP:	9
Total Census of ALP:	77

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

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

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Other

Incident Allegation: It was reported by the program, a tenant fell on 3-11-10 and 3-12-10. The tenant's doctor was notified and Seroquel was discontinued. The tenant slid out of his/her recliner on 3-13-10 and was found on the floor at another time on 3-13-10. The tenant and family declined to seek medical attention at that time. It was reported that on 3-14-10 a tenant slid out of his/her recliner and was on the floor. The tenant agreed to be transported and was seen at the emergency room (ER). The tenant had three rib fractures.

Monitoring Observation: Tenant #1, 85 years old, was admitted on 1-4-08 and diagnoses include: Hypertension (HTN), Dementia and Atrial Fibrillation. The tenant was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.

Incident reports for the last three months were reviewed. According to an Incident Report dated 3-11-10 at 4:30 a.m., the tenant fell next to the bed and did not sustain any injuries. The tenant's doctor, the nurse and the tenant's family were notified and a PRN nurse review was completed. According to an Incident Report dated 3-12-10 at 3:10 a.m., the tenant paged staff and he/she was found on the floor by the bed. The tenant did not sustain any injuries. The tenant's doctor, the nurse and the tenant's family were notified and a PRN nurse review was completed. According to an Incident Report dated 3-13-10 at 5:45 a.m., the tenant fell in the living room by the recliner and had a skin tear on the left elbow. The tenant's doctor, the nurse and the tenant's family were notified and a PRN nurse review was completed. According to an Incident Report dated 3-13-10 at 10:30 a.m., the tenant was found on the floor in the doorway of the bathroom. The tenant did not complain of pain but had two skin tears on his/her elbows. The tenant's doctor, the nurse and the tenant's family were notified and a PRN nurse review was completed. According to an Incident Report dated 3-14-10 at 11:50 a.m., the tenant was found on his/her side on the floor. The tenant had lower back and right side pain. The nurse and the tenant's family were notified and a PRN nurse review was completed. In the past three months the tenant had one additional report, dated 2-19-10, where the tenant was found on the floor and did not have any injuries.

On 2-23-10, the nurse faxed the tenant's doctor regarding sexual comments the tenant made to staff. The nurse indicated the tenant was easily redirected but the comments continued and she asked if there was anything they could or should be doing. The tenant's doctor ordered Seroquel, 25 mg, at bedtime and this was reflected on the tenant's Medication Administration Records (MARs). On 3-12-10 the nurse faxed the tenant's doctor and indicated the tenant had fallen three times since 2-20-10. Since starting the Seroquel the tenant was more lethargic and had started to drool. The doctor discontinued the Seroquel on 3-12-10 and this was reflected on the tenant's MARs.

A nurse review and evaluations were completed on 2-23-10, related to behaviors and the initiation of Seroquel. The tenant's service plan was updated on 2-23-10 to reflect the sexual comments that were made and interventions related to the behavior. According to the tenant's service plan, under Mobility, the tenant was independent with an assistive device and had a history of falls.

A PRN nurse review was completed on 2-25-10, which noted no adverse effects from the Seroquel. A PRN nurse review was completed on 3-12-10 at 1:30 p.m., after the Seroquel was discontinued. An additional PRN nurse review was completed on 3-12-10 at 4:00 p.m. and PRN nurse reviews were completed in regard to the falls that occurred on 3-11-10, 3-12-10, 3-13-10 and 3-14-10.

According to Physical Therapy (PT) documents, the start of service was 2-22-10 and the tenant was discharged on 3-10-10. The tenant was seen for improvements in safety with mobility, gait, strengthening and endurance. PT was reflected on the tenant's service plan.

Staff #1, the Registered Nurse (RN) on-call during this time, was interviewed. She stated she worked on 3-12-10 and was on-call on 3-13-10 and 3-14-10. On 3-12-10 the tenant slid and did not complain of any pain, she assessed the tenant and he/she did not have any injuries. She stated the tenant's doctor discontinued the Seroquel on 3-12-10. On 3-13-10, she assessed the tenant and he/she stated he/she needed to lie down, was not feeling great and had a little discomfort in the lower back. She encouraged the tenant to go out for an evaluation and the tenant declined. She called the tenant's family and they agreed with the tenant's decision to decline outside medical evaluations. The RN said it was a team decision and family followed the tenant's lead. She stated the tenant was smiling and vitals were good at that time. In her nursing judgment, if the tenant would have gone out he/she would have been sent right back to the program. She stated it was not a significant change for the tenant and the tenant's doctor was notified. The nurse was called on 3-14-10 and was told the tenant slid and did not have any major complaints at that time. She told staff to call if there was a change. The nurse assessed the tenant on 3-14-10 and he/she had no complaints until she touched the tenant's side. The tenant then complained of side pain and tenderness. The nurse told the tenant he/she needed to be seen by a physician and the tenant agreed. The tenant was sent out to be evaluated and at the time of the investigation was at a rehabilitation facility. The nurse stated she was notified of the falls and assessed the tenant on 3-12-10, 3-13-10 and 3-14-10. The nurse stated the situation was handled appropriately.

The Health Care Coordinator was interviewed. She stated the tenant was independent with mobility and used a walker. The tenant had a history of falls; however, none with significant injuries. She stated the tenant had made sexual comments to staff and Seroquel was initiated. The tenant had increased lethargy and drooling and the doctor was notified immediately and it was discontinued. On 3-11-10 the Health Care Coordinator was notified of a fall and the tenant did not have any injuries. She stated Staff #1, an RN, was the nurse on-call for the weekend and staff notified her.

The Personal Emergency Response System (PERS) records were reviewed from 3-11-10 through 3-14-10 for Tenant #1. The tenant activated the PERS six times with an average response time of 1:41 minutes and a maximum response time of 2:24 minutes.

Two additional tenant files were reviewed from tenants that had falls and the files were appropriate.

- Regulatory Insufficiency: None noted. Dated this 21st day of April, 2010.