IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

December 6, 2010

Incident Intake #: 31307-I

Ms. Christine Cross, Manager
Solon Assisted Living Village
623 East 5th Street
Solon, IA 52333

RE: Final Incident Investigation & Initial Certification Monitoring Evaluation Report, Solon Assisted Living Village, Solon, IA

Dear Ms. Cross:

Enclosed is the **Final Incident Investigation & Initial Certification Monitoring Evaluation Report** completed 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. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiency, DIA accepts your POC and certification of Solon Assisted Living Village will continue.

Enclosed you will find the Assisted Living Program Certificate **S0306** with effective dates of **December 28, 2009** through **December 27, 2011**. This certificate is to be posted in the building for public viewing.

If you have any questions regarding this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation & Initial Certification Monitoring Evaluation Report

Assisted Living Program:

Incident Intake #: 31307-I

Christine Cross, Manager
Solon Assisted Living Village
623 East 5th St.
Solon, IA 52333

Date of Incident Investigation & Monitoring Visit:

November 2, 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. IAC r. 481-67.10(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 Solon Assisted Living Village on November 2, 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:	19
Current number of tenants with cognitive disorder:	1
Total Population:	20

Dementia Specific Program (DSP)* – Not applicable.

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

Tenant/Family Satisfaction Results – A community meeting with 10 tenants and 1 visitor was held. The tenants reported the apartments were cleaned one time per week and no improvements were needed with housekeeping, laundry or maintenance. Staff responded quickly when called, one tenant said within two minutes. They were getting what was promised when they moved into the program. Staff treated the tenants with respect and knocked before they entered their apartments. One tenant was ill recently and staff brought the tenant a piece of toast. The tenants described staff as excellent, wonderful and great. They received all of the services they required. Generally, the tenants liked the food; however, they reported the temperature of the hot foods needed improvement. One tenant requested more diabetic options for desserts and one tenant said at times the meat was tough. There were sufficient activities offered for the majority of the tenants; however, two tenants requested more activities. They enjoyed exercises and church services. The tenant felt safe and reported they made their own decisions. The tenants were satisfied with the program and would recommend it to others. One tenant said he/she liked the small size of the program.

Program History – The program received no regulatory insufficiencies during this certification period.

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

A. Nurse Review

- Monitoring Observation: Tenant #1, an 81 year old, was admitted on 10-1-10 and diagnoses include Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Hypertension (HTN) and Osteoporosis. The Nurse Coordinator indicated she based the Medication Administration Record (MAR) on the discharge summary and MAR from the previous facility. The program's MAR was faxed to the doctor on 10-1-10. On 10-4-10 the Nurse Coordinator called the office and was told the doctor was on vacation. The tenant had an appointment with a new doctor on 10-6-10. The MAR from the previous facility indicated the tenant was ordered oxygen at 2-4 liters continuous during the day and at 4 liters during the night and may remove for bathing and bathroom. The MAR from the previous facility also indicated may taper the oxygen down but maintain sats 90% and above. The program's MAR, which was faxed to the doctor, did not include oxygen. The doctor signed the MAR on 10-18-10. The tenant was admitted on 10-1-10, sustained a hip fracture on 10-6-10 and had not returned to the program at the time of the onsite. The tenant's October 2010 MAR indicated change nasal cannula every week and change extension tubing every month; however, an order for oxygen was not listed on the MAR. The tenant's service plan listed oxygen needs (under Coordination of Outside Services); however, an order for oxygen was not found. The program did not ensure orders were current for tenants who received health care professional-directed care from the program.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

B. Other

Incident Allegation: It was reported a tenant was washing dishes and pushed his/her pendant to alert staff. It was reported staff responded and found the tenant on the floor. It was reported the tenant was sent to the hospital and was diagnosed with a hip fracture.

- Monitoring Observation: Tenant #1's file was reviewed. According to an Incident Report dated 10-6-10 at 7:15 a.m. the tenant said he/she was standing and then fell. The tenant landed on his/her right side and used the pendant to call for staff assistance. Staff responded and one staff stayed with the tenant and another staff called the Nurse Coordinator. The Nurse Coordinator responded immediately and a set of vitals were obtained. The tenant's family and physician were notified. The tenant was rolled onto his/her back and no swelling or bruising was noted. The tenant complained of pain when the right was moved. The tenant was admitted to the hospital.

  Staff #3 said on the day of the incident the tenant requested a tray for breakfast and she took the tenant a tray. The tenant was sitting the in living room area of the apartment. Approximately 30 to 45 minutes later the tenant pushed the pendant and

Staff #3 responded in approximately one to two minutes. She found the tenant lying on his/her side in the kitchen area of the apartment. The tenant reported he/she had fallen. The tenant was on oxygen; however, did not have the oxygen on at that time. She got another staff to assist and she called the Nurse Coordinator. The Nurse Coordinator arrived quickly and vitals were obtained. The Nurse Coordinator called the tenant's family. The Nurse Coordinator completed an assessment and a pillow was put under the tenant's head. An ambulance was called and the tenant was sent out. The tenant had not returned at the time of the onsite. She said the incident was handled appropriately.

The Nurse Coordinator said staff called her the morning of 10-6-10 and told her the tenant was on the floor. She responded and the tenant was lying on his/her back in the kitchen area of the apartment and was comfortable. The tenant reported he/she was doing dishes and then went down on the right side. She started a head to toe assessment. When she moved the tenant's leg out or up the tenant complained of pain. There was no bruising or swelling. The tenant refused to go to the hospital and wanted a family member called. A pillow was put under the tenant's head to make the tenant more comfortable. A family member arrived and family and the tenant agreed to be sent out. This was the first time the tenant was in agreement to go to the hospital and 911 was called. The tenant sustained a right hip fracture and had surgery. At the time of the onsite the tenant was at a skilled nursing facility for rehabilitation. The Nurse Coordinator said staff response to the incident was appropriate.

According to the Incident Report the incident occurred at 7:15 a.m. on 10-6-10. Records from the Personal Emergency Response System (PERS) were reviewed and indicated on 10-6-10 at 7:10 a.m. the tenant pushed the pendant and staff responded at 7:12 a.m. Staff responded in two minutes, according to the PERS records.

Evaluations were completed and the service plan was developed prior to taking occupancy. According to the tenant's service plan dated 9-26-10, the tenant would call for assistance to ambulate around apt and around building with a wheelchair.

The Nurse Coordinator indicated the tenant had fallen at night prior to the incident. The tenant was supposed to call for assistance getting up and did not call. Interventions included re-education to call for assistance and to always have the walker with the tenant. An order was received for Physical Therapy (PT) to evaluate and treat dated 10-5-10.

The program reported the fall with significant injury to the department appropriately and there was an incident report related to the fall on 10-6-10.

Staff #1, #2 and #3 did not identify any tenants that exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

Dated this 3rd day of December, 2010.