IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Incident Intake #: 31418-I

December 30, 2010

Ms. Kelsie Weldon, Administrator
Park Lane Village
908 South Park Lane
Knoxville, IA 50138

RE: Final Incident Investigation Report, Park Lane Village, Knoxville, Iowa

Dear Ms. Weldon:

Enclosed is the **Final Incident Investigation 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, 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 Report

Assisted Living Program: **Incident Intake #: 31418-I**

Kelsie Weldon, Administrator
Park Lane Village
908 South Park Lane
Knoxville, IA 50138

Date of Investigation:

December 15, 2010

Monitor(s):

Joyce Kix, RN
Lori Miner, RN BSN

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 a Complaint 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 Park Lane Village on December 15, 2010. In preparing this report, the following information was considered:

Current Program Census

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

Current number of tenants without cognitive disorder:	55
Current number of tenants with cognitive disorder:	4
Total Population:	59

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.**

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Structural requirements

Incident Allegation: The program reported on 10-14-10, Tenant #1 tripped on carpet trim that lined the dining room on 10-13-10, which resulted in a fall and fractured hip.

Monitoring Observation: Tenant #1, a 90 year-old, was admitted on 3-20-2002 with a diagnosis of Alzheimer's Dementia. The tenant scored five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. An assessment dated 9-1-10 indicated the tenant was independent with mobility, and able to walk without assistance. An incident report dated 10-13-10 indicated the tenant was leaving the dining room and tripped over "that piece" on the floor and went down. The tenant was transported to the hospital via ambulance, and treated for a fractured hip. An attempt was made to interview Tenant #1, but the tenant did not remember the incident.

Incident reports for the past three months were reviewed. One other tenant identified as falling in the dining room on 10-2-10 stated he/she just slipped and fell.

Observation on 12-15-10 of the rubber trim which transitioned the floor from tile in the dining area to the carpet of the lobby revealed no loose trim. Several areas of obvious repair were noted.

Tenant #3 was interviewed and indicated the trim had been loose on the floor and that the program was aware of it because he/she had told them about it. The trim was described as being higher than the tile with a lip.

A review of the Resident Council notes from 7-9-09 through 12-9-10 indicated no concerns were raised by the tenants regarding loose trim around the dining room tile.

The incident report for Tenant #1, dated 10-13-10, indicated Staff #1 and #2 were witnesses to the fall. Staff #1 was interviewed by phone and indicated Tenant #1 was leaving the dining room and fell on the strip that goes around the carpet. Staff #1 described the trim as loose and raised, and had been that way for two to three months.

Staff #3, the former administrator, indicated Tenant #1 tripped on the rubber strip in the dining room. The strip was described as having a few places to snag a toe. This staff described the strip as gradually loosening when walkers hit the trim. Staff #3 indicated the program had been notified by Tenant #3 the floor trim was loose. The administrator reported that a flooring company had been contacted two days before the incident and the program had been placed on a list for future repair. After the incident, but on the same day, the flooring company was again contacted and instructed to fix the problem and not to put the problem on a list of things to do. Staff #3 reported that after Tenant #1's fall, Staff #2 put duct tape down to hold the trim until it could be fixed.

The program provided an invoice dated 10-23-10 from the flooring company which indicated the trim strip was glued and the lip was lowered from the carpet to the tile.

The program was aware of a problem with the trim strip on the floor between the dining room tile and the carpeting prior to a fall which occurred on 10-13-10 and failed to take immediate action to correct the problem to maintain safety of the tenants.

The incident was reported to the department appropriately on 10-14-10.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

Dated this 29th day of December, 2010.