IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

March 2, 2011

Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233

RE: Final Incident Investigation & Recertification Monitoring Evaluation Report – Promise House, Hiawatha, IA

Dear Mr. Walton:

Enclosed is the **Final Incident Investigation & Recertification 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.

DIA has completed the review of your Plan of Correction (POC) in response to the Preliminary Incident Investigation & Recertification Monitoring Evaluation Report. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiency, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0090** with effective dates of **July 19, 2010** through **July 18, 2012.**

If you have any questions in regard to 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 & Recertification Monitoring Evaluation Report

Assisted Living Program: **Incident Intake #: 32765-I**

Kent Walton, Administrator
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233

Date of Incident Investigation/Monitoring Visit:

February 8, 2011

Monitor(s):

Stephanie Cummins, MA
Maribeth Freland, RN

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 Promise House in Hiawatha on February 8, 2011. In preparing this report, the following information was considered:

Current Program Census:

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

Total Population of DSP:	16
Total Census of ALP:	16

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

Tenant/Family Satisfaction Results – Two family interviews were held. They reported the building was clean and had a great atmosphere. They were pleased with the care provided and reported the Director was involved and family could go to her with any concerns. They reported there was good communication and families were notified of issues appropriately. They felt the tenants were safe and liked the small size of the program. They did not have any complaints regarding food and were welcomed as visitors. There were not a lot of structured activities; however, spontaneous activities occurred and they did not request additional activities. The monitors observed the program was clean and had a nice atmosphere. The meal was observed and the food looked appetizing. Various activities were observed including: music, word puzzles and puzzles. Staff were respectful and polite towards the tenants.

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. Service Plan

- Monitoring Observation: Five tenant files were reviewed.

  Tenant #1, a 78 year old, was admitted 10-14-09 with diagnoses of: Alzheimer's Disease, Hypertension (HTN), Depression, Osteoarthritis and History of Stroke. The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline.

  The tenant's clinical record contained a note to the physician, dated 12-1-10 and completed by the Program Director, who is also a registered nurse (RN). The note indicated the Director identified Tenant #1's right foot to resemble foot drop. Staff had noted the tenant had begun dragging the foot with ambulation, which caused him/her to stumble and fall more frequently. The Director reported the physical therapist used by the program suggested the staff wrap the tenant's ankle with an elastic bandage to stabilize the tenant's ankle and observe tenant response over time. The physician responded by approving the staff to wrap the tenant's right ankle with the elastic bandage.

  The tenant's clinical record lacked any documentation that indicated the staff had initiated the physician ordered wrapping of the tenant's ankle.

  The Director reported Tenant #1 had required wrapping of the ankle with an elastic bandage beginning on 12-1-10; however, she could not remember how long the wrapping continued. The Director believed the wrapping was discontinued when the tenant received a brace for the right leg. (The clinical record indicated the program initiated use of the right leg brace on 12-27-10) The Director reported she and Staff #1, a licensed practical nurse (LPN), wrapped the tenant's ankle when available and universal workers had been trained to perform the wrap when the RN and LPN could not.

  The Director reviewed Tenant #1's clinical record and indicated direction to staff to perform the wrapping of the tenant's right ankle would have been placed on the Medication Administration Record (MAR) for staff signature when completed. The Director reviewed the MAR for December 2010, finding no such direction to staff. The Director reviewed the Care and Service Plans for the same time period, finding no direction to staff to wrap the tenant's right ankle.

  The service plan did not address the tenant's identified needs.

  Tenant #2, a 91 year old, was admitted on 12-14-09 and diagnoses include: Dementia (Alzheimer's Type), HTN, Osteoporosis, Hyperlipidemia, Hyperglycemia, Anemia and Depression. The tenant was staged at a six on the GDS, which indicated severe cognitive decline.

  According to Occurrence Reports, on 1-5-11 and 1-12-11 the tenant was found on the floor. On 1-21-11 the tenant stood up, his/her knees buckled and the tenant was lowered to the floor, according to the report. On 1-25-11, the tenant scooted to the edge of the chair and tipped the chair forward trying to stand up. The chair tipped

forward and the tenant sat on the floor, according to the report. On 1-31-11 the tenant fell and hit his/her head on the door. On 2-1-11 the tenant was found lying on his/her back with legs up in the air. The tenant's left leg was observed with the bone protruding out above the knee and the tenant was transferred to the hospital, according to the report. According to a clarification to the doctor, when the tenant was found on the floor, the bone was not protruding through the skin on the left leg and there were no open areas. The tenant was transferred to the hospital.

According to Nurse's Notes dated 2-2-11, the hospital reported the tenant had a fractured left femur and had surgery. The tenant was transferred to a nursing facility. The Director stated the tenant was discharged on 2-7-11.

The service plan was updated on 2-1-11 and reflected the tenant's restlessness and sleep habits including coming out at night to the common area. The service plan did not reflect the tenant's fall history. The service plan did not address the tenant's identified needs.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

B. Other

Incident Allegation: The program reported a tenant was found on the floor next to the bed on his/her back with his/her legs in the air and knees flexed. It was reported the tenant's bone was protruding out just above the knee. It was reported the tenant had five falls in January and one fall in February.

- Monitoring Observation: Tenant #2's file was reviewed. According to an Occurrence Report dated 2-1-11 at 10:10 p.m., staff heard a noise and upon entering the tenant's apartment they found lying on his/her back with legs up in the air. The tenant's left leg was observed with bone protruding out above the knee and the tenant was transferred to the hospital, according to the report. According to a clarification to the doctor, when the tenant was found on the floor the bone was not protruding through the skin on the left leg and there were no open areas.

  According to Nurse's Notes dated 2-1-11 at 9:50 p.m. the tenant was checked on and was asleep. At 10:10 p.m. staff heard a noise and found the tenant lying on his/her back with legs up in the air. The tenant's left leg was observed with bone protruding out above of the knee. The tenant denied pain when asked, according to notes. Ice was applied and the left leg was immobilized as much as possible with the tenant's restlessness. The tenant's family was notified and the ambulance was called. The ambulance arrived at 10:30 p.m. and left for the hospital at 10:45 p.m. At 5:00 a.m. on 2-2-11, the hospital reported the tenant had a fractured left femur. Notes indicated the tenant had surgery to repair the fractured femur. The tenant was transferred to a nursing facility on 2-5-11. The Director stated the tenant's discharge date was 2-7-11.

  Staff completed checks every hour from 11:00 p.m. to 6:00 a.m. and documented those checks. The incident with the tenant occurred prior to the documentation of the

checks was required. Notes indicated the tenant was checked on at 9:50 p.m. and asleep prior to the incident.

The Director and Staff #1 worked at the time of the incident.

The Director said they were listening to report and heard something. The Director and Staff #1 went to the tenant's room. They found the tenant lying on the floor. The tenant denied pain, according to the Director. She noticed the tenant's left leg bone was out of alignment; however, was not out skin. She called the tenant's family member and called the ambulance. She stayed with the tenant on the floor and she put her leg under the tenant's leg as much as possible. Ice was applied right away, according to the Director. She reported the ambulance arrived and they left at 10:45 p.m. The Director stated the tenant did not like to be alone and they had moved the tenant's apartment closer to the common area and staff. The Director stated the tenant walked independently; however, if the tenant was unsteady staff assisted. They were made aware of the fracture on 2-2-11. The Director stated the situation was handled appropriately.

Staff #1 stated she had just finished report and they heard a noise. She went to the tenant's room and the tenant was found on his/her back. The tenant smiled and was happy. She stated it was observed part of the tenant's femur was displaced and there was a bruise on the skin. The area was swollen and ice was applied. She said the Director called the ambulance and family and provided comfort. The ambulance arrived quickly. She stated she had seen the tenant 10 minutes before and the tenant was asleep.

An incident report was completed regarding the incident. The tenant was discharged on 2-7-11.

The physician, Designee of Physician, or Physician Extender completed a Major Injury Determination Form and indicated the injury sustained was not a major injury. The form was signed on 2-7-11.

- Regulatory Insufficiency: None noted.

Dated this 1st day of March, 2011.