IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33191-I

April 4, 2011

Cheryl Rogan, Director of Housing
Oak Park Place
1381 Oak Park Place
Dubuque, IA 52002

RE: Final Incident Investigation Report – Oak Park Place, Dubuque, IA

Dear Ms. Rogan:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of March 22, 2011, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program: **Incident Intake #: 33191-I**

Cheryl Rogan, Director of Housing
Oak Park Place
1381 Oak Park Place
Dubuque, IA 52002

Date of Incident Investigation:

March 22, 2011

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 Oak Park Place on March 22, 2011. 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:	42
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	44

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

Total Population of DSP:	17
Total Census of ALP:	61

***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: The program reported a tenant got up independently to go to the bathroom and fell. It was reported the tenant's spouse responded by hitting the pendant for assistance. The program reported a caregiver responded and summoned the nurse. It was reported the nurse assessed the tenant with need for emergency care. The tenant sustained a left distal femur fracture.

- Monitoring Observation: Tenant #1, an 89 year old, was admitted on 2-5-11 and diagnoses include: Alzheimer's Disease, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, Hypertension (HTN), Hyperthyroidism and Macular Degeneration. The service plan indicated (under Toileting) assist of one needed. Check on tenant every couple of hours/before every meal. Staff to encourage the tenant to push pendant for help and not to rely on spouse to escort. The service plan indicated (under Mobility) the tenant used a walker in the room with assistance and a wheelchair to dining room, activities or other long distances. According to Admission Notes, the tenant had scars on both hips from total hip surgeries. The note indicated the tenant used to fall a lot.

  According to an Incident Report on 3-4-11 at 3:15 p.m. the tenant's spouse paged and staff found the tenant lying on the shower floor. The tenant did not hit his/her head; however, complained of left leg pain. The tenant stated he/she was transferring from the wheelchair to the toilet and lost his/her balance. The incident occurred in the tenant's bathroom. Vitals were obtained, 911 and family were called. According to an Incident Report on 2-19-11 at 3:00 p.m. the tenant was found lying on the bathroom floor and tried to get up independently. The tenant had a skin tear on the knee and elbow and a blood blister on the lower leg.

  Staff #1 stated he responded to the page and found the tenant lying in the shower. The tenant had attempted to transfer from the wheelchair to the toilet and the wheels were locked on the wheelchair. The tenant did not have a head injury; however, complained of leg/thigh pain. Staff #1 did not move the tenant and notified Staff #2, a licensed practical nurse (LPN). Staff #2, the Director of Housing (DOH) and the Director of Nursing (DON) came to the tenant's apartment. They took over from that point and he returned to the medication pass.

  Staff #2, LPN, stated she was called by one of the staff and she responded in two minutes. She saw the tenant lying on the bathroom floor with the back of the tenant's head toward the shower. She did not do range of motion (ROM) because the tenant complained of leg pain. She said ROM to upper extremities was fine. There was no bruising or swelling and no head injury. She took vitals and did not move the tenant's leg. The tenant told her he/she tried to get off the toilet and fell. The tenant usually called for help and that time he/she tried to do it independently. She called the tenant's family and notified the DON. The DON responded and took over.

  The DON stated Staff #1 paged for a nurse and Staff #2 responded. Staff #2 then paged for the DON. She went to the tenant's apartment and she assessed the tenant. She pinpointed the pain to just above the knee and any movement in the knee area

was painful. A pillow was put under the tenant's head and under the left knee in the position the tenant had it in. Vitals were taken and Emergency Medical Services (EMS) was called to transport the tenant to a local hospital. The tenant's family was contacted by Staff #2 and the DON. The tenant sustained a femur fracture and had a brace. The fracture did not require surgical repair. The tenant was transferred from the hospital to a skilled nursing facility. The tenant and the tenant's spouse were on a toileting schedule to try to prevent falls. The time of the incident was not at a scheduled time for toileting. The tenant had just returned from an appointment and took himself/herself independently. The DON stated the response to the incident was timely and accurate.

Tenant #2, the tenant's spouse was interviewed. The tenant stated Tenant #1 had needed to use the toilet. The tenant got Tenant #1 in the bathroom and seated and then waited outside. The tenant heard Tenant #1 fall and tried to get in the door to help but could not get in. The tenant pushed the pendant and staff responded quickly, in approximately three minutes. Staff responded and then requested another staff. The tenant stated there was a good response from staff.

The pendant history on 3-4-11 was reviewed and indicated the tenant's spouse activated his/her pendant at 3:04 p.m. and the response time was just over seven minutes.

A sample of the pendant history was reviewed and showed entries where staff reported the pendant did not cancel properly. The DOH reported there were no issues reported from the tenants and there were concerns with pendants not being able to be activated. There was some trouble with shutting off pendants and the maintenance staff had been working on the issue. Two tenants were interviewed and did not report any issues with staff response to the pendant system.

At the time of the investigation the tenant was at a skilled nursing facility and had not returned.

An incident report was completed related to the incident. The program notified the department appropriately.

- Regulatory Insufficiency: None noted.

Dated this 4th day of April, 2011.