IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33745-I

May 20, 2011

Mr. Jerry Bell, Manager
Sunset Park Place
3730 Pennsylvania Avenue
Dubuque, IA 52002

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

Dear Mr. Bell:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of May 3, 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 #: 33745-I**

Jerry Bell, Manager
Sunset Park Place
3730 Pennsylvania Avenue
Dubuque, IA 52002

Date of Incident Investigation:

May 3, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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 Sunset Park Place on May 3, 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:	47
Current number of tenants with cognitive disorder:	1
Total Population of GPP:	48

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

Total Population of DSP:	6
Total Census of ALP:	54

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

Program History – There were 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 was found on the floor and the tenant sustained a hip fracture.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 9-29-07 and diagnoses include: Parkinson's Disease, Congestive Heart Failure (CHF), Diet Controlled Diabetes, Chronic Dizziness, History of Urinary Tract Infection (UTI) and Compression Fractures. At the time of the incident the tenant received Hospice services. The service plan indicated the tenant did not always remember to page for assistance when he/she had to go to the bathroom until the tenant was already seated on the toilet. The service plan indicated the tenant was a fall risk and staff performed eight visual checks per shift to ensure the tenant was safe. The service plan also indicated the tenant used a walker; however, used a wheelchair for long distances when the tenant was unsteady. The tenant used a lift chair for standing and did not want to ambulate to the dining room or activity room without stand by assistance (SBA), according to the service plan.

  According to an Incident Report, on 4-18-11 at 1:00 a.m. the tenant was found on the floor of the apartment on the tenant's right side. The tenant reported he/she was going to the commode and could not find his/her pendant; however the pendant was around the tenant's neck. The tenant was lifted to the bed and asked if the tenant could stand. The tenant could not stand and complained of pain. The incident report indicated the tenant was very calm. The tenant's family, Hospice and paramedics were called, according to the report. According to Nurse's/Care Notes the tenant had a hip fracture and it was surgically repaired. At the time of the investigation the tenant was at a skilled nursing facility.

  Staff #1 stated he completed hourly checks at 11:00 p.m. and 12:00 a.m. and at 12:45 a.m. he was paged for assistance. He found the tenant on his/her side by the commode. There were no visible injuries and no complaints of pain. The tenant was lifted on to bed. He noticed the tenant's leg was shaking. He called Staff #2, a licensed practical nurse (LPN). She arrived in approximately 10 minutes and Staff #1 stayed with the tenant until Staff #2 arrived. Staff #2 assessed the tenant and called Hospice and paramedics. Staff #2 stayed with the tenant until the paramedics arrived. Staff #1 was an emergency medical technician (EMT) basic. He stated the situation was handled appropriately and the tenant received good care. He stated the checks were completed appropriately for the tenant. Staff #1 stated there were enough staff to meet the needs of the tenants and he did not identify any tenants that exceeded the appropriate level of care.

  Staff #2, a LPN, was called immediately when Staff #1 responded to the tenant. She arrived within 10 minutes. She called Hospice, paramedics and the tenant's family. She assessed the tenant and he/she complained of pain in the upper thigh. She was called at approximately 1:00 a.m. and the ambulance arrived at 1:30 a.m. She stated the situation was handled appropriately and the tenant received exceptional care. Staff #2 stated checks were completed appropriately for the tenant. Staff #2 stated

there were enough staff to meet the needs of the tenants and she did not identify any tenants that exceeded the appropriate level of care.

The nurse was out of town when the incident occurred and was notified the next morning via email that the tenant had fallen and fractured his/her hip. The nurse stated the tenant did not have any other falls with significant injury; however, the tenant had previously fallen out of bed and out of a chair. She stated staff handled the situation appropriately and the tenant received good care. The nurse stated there were enough staff to meet the needs of the tenants and she did not identify any tenants that exceeded the appropriate level of care.

According to an Incident Report, on 3-7-11 staff found the tenant on the floor outside the bathroom and the tenant denied pain. The tenant did not sustain any injuries. According to an Incident Report, on 3-27-11 the tenant paged for assistance and staff found the tenant on the floor. The tenant reported he/she slid off of the chair and was lying on the left side. The tenant did not sustain any injuries.

According to Visual Hourly Resident Checks documents, checks eight times per shift were consistently documented for the tenant. Records indicated checks were completed at 11:00 p.m. on 4-17-11 and at 12:00 a.m. on 4-18-11.

The pendant history was reviewed related to the incident. The history indicated the tenant's pendant was activated on 4-18-11 at 12:48 a.m. and it was cleared at 12:49 a.m.

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

- Regulatory Insufficiency: None noted.

Dated this 20th day of May, 2011