IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33983-I

May 25, 2011

Ms. Lisa Hanson, Nurse Manager
SunnyBrook of Mt. Pleasant
1406 East Linden Drive
Mt. Pleasant, IA 52641

RE: Final Incident Investigation Report – SunnyBrook of Mt. Pleasant, Mt. Pleasant, IA

Dear Ms. Hanson:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of May 16, 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 #: 33983-I**

Lisa Hanson, Nurse Manager
SunnyBrook of Mt. Pleasant Assisted Living
1406 East Linden Drive
Mount Pleasant, IA 52641

Date of Incident Investigation:

May 16, 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 SunnyBrook of Mt. Pleasant Assisted Living on May 16, 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:	32
Current number of tenants with cognitive disorder:	0
Total Population of GPP:	32

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

Total Population of DSP:	12
Total Census of ALP:	44

***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 past certification period.

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

A. Other

Incident Allegation: The program reported staff took a tenant to his/her apartment and assisted the tenant to a recliner. Staff went to the front of the building and heard a noise. Staff returned to the apartment and found the tenant lying on the left side and the tenant was semi-face down. The program reported the tenant did not activate his/her pendant for assistance. The tenant complained of pain, he/she was not moved and 911 was called. The tenant sustained a left hip fracture.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 7-1-09 and diagnoses include: Dementia (Short Term Memory Loss), Vertebral Artery Syndrome, Transient Ischemic Attack (TIA), Hypertension (HTN), Diabetes Mellitus (DM) II, Hypercholesterdemia, Hyperlipidemia and Anemia.

  According to an Event Report, on 5-1-11 at 6:00 p.m. the tenant was found lying on his/her left side. The tenant complained of left shoulder and left hip/leg pain. The Nurse Manager was notified on 5-1-11 at 6:10 p.m. The tenant was transferred by ambulance to a local hospital. According to an Event Report, on 4-22-11 at 11:45 a.m. the tenant had been asleep in a lounge chair in the living room when staff heard a loud noise. The tenant was found lying on his/her left side next to the chair.

The tenant stated he/she had tripped over his/her own foot. The tenant denied any pain or injury at that time.

According to Nurse's/Care Notes dated 4-22-11 the tenant was seated in the community living room and had been napping. The tenant stated he/she tripped over his/her own foot which caused the tenant to fall. The tenant ambulated without difficulty and there were no injuries noted at that time. Notes dated 4-23-11 indicated the tenant was unable to stand and took two staff to transfer. The tenant's family took the tenant to the emergency room (ER). Notes dated 4-24-11 indicated the x-rays were negative. Notes dated 4-26-11 indicated the tenant continued to complain of discomfort in left hip area and bruising had started in the hip region. The tenant was able to stand independently without difficulty; however, he/she could not step due to complaints of severe pain with bearing weight on the left leg. The tenant was seen by the doctor on 4-26-11 and another x-ray was taken. The x-ray was negative for a fracture; however, the tenant had a contusion to the left hip. The doctor ordered a walker, discontinued Coumadin, started Aspirin 81 mg every day, Milk of Magnesium (MOM) was changed to scheduled and reassess the need for home health for physical therapy (PT) after one week (5-2-11). Evaluations were completed and the service plan was updated to reflect changes. The service plan dated 4-26-11 indicated the tenant fell on 4-22-11 and sustained a left hip contusion. The tenant had difficultly ambulating due to the pain. Staff needed to assist the tenant with ambulation with a walker and transfers. Notes indicated on 5-1-11 the tenant was found lying on his/her left side. The tenant was transported to a local hospital and was transferred to another hospital for surgical repair of a fractured left hip. The tenant was transferred to the skilled nursing facility (SNF) at the hospital and returned to the program on 5-11-11, according to notes. Evaluations were completed and the service plan was updated on 5-11-11.

Staff # 1 stated after supper Tenant #1 was assisted to his/her room. She stated she had told the tenant repeatedly to push the call button if the tenant needed anything. Approximately five to ten minutes later, one of the kitchen staff heard someone yell. The tenant was found face down on the floor with the tenant's left arm under her body. The tenant complained of shoulder pain. She checked the tenant's vital signs while other staff called the Nurse Manager.

Staff # 2 stated after supper, she and Staff #1 walked Tenant #1 back to his/her room and got the tenant settled in the recliner. Later she thought she heard a noise and at the same time kitchen staff approached her and stated someone was calling for help. The tenant was found on the floor face down. She called the Nurse Manager who advised her to call 911 for transport to the ER. She stated they tried to roll the tenant onto her back; however, the tenant moaned so they did not move him/her.

Staff # 4, a dietary staff, stated she was clearing dishes off the tables in the dining room when she heard a howling noise coming from a hall. She looked down the hall and did not see anything; however, the yelling continued, so she walked down the hall. She saw Tenant #1 in their apartment, lying on the floor on the tenant's left side with a wooden kitchen chair on top of the tenant. She removed the chair and went to the kitchen to ask Staff # 5 if she knew where the caregivers were in the building. At the same time she was talking to Staff # 5, staff were coming down the hallway as they had also heard the tenant calling for help.

She went to the doorway of the apartment to make sure the staff did not need any additional help. They did not need any assistance, so she returned to clearing dishes in the dining room.

The Nurse Manager stated she received a phone call from Staff #2 at approximately 6:00 p.m. She was told Tenant #1 was found on his/her left hip, body twisted and face down. Staff #2 reported that shortly after supper the tenant was assisted to the apartment and helped into the recliner. Approximately 30 minutes later, staff heard a noise and went to the tenant's apartment. When staff tried to turn the tenant, he/she cried out in pain, so the tenant was left in the position in which he/she was found and 911 was called. The Nurse Manager waited 10 to 15 minutes and then called back. At that time she was told the emergency medical technicians (EMTs) had arrived and had moved the tenant. The Nurse Manager called the tenant's family member and left a voice mail about the incident. Between 8:30 p.m. and 9:00 p.m., she spoke with the local ER staff that stated the tenant was transferred to another hospital for repair of the fractured hip. The next day, the Social Worker from the hospital called after surgery and stated the tenant had been transferred to a SNF at the hospital. The tenant returned to the program on 5-11-11.

Staff #1 and #2 stated none of the tenants exceeded the appropriate level of care and there were enough staff to meet the needs of the tenants. Staff #1, #2 and the Nurse Manager stated the tenant received appropriate care and the situation was handled appropriately.

Tenant #1 was interviewed. The tenant was not able to recall the details surrounding the recent fall that resulted in a hip fracture. He/she did know how to use the pendant; however, had not called for help very often. Staff treated the tenant very nicely, were trained appropriately and knew what services to provide. Staff did whatever was requested and responded immediately when called. The tenant stated it was great living at the program. The tenant was satisfied with the program, felt safe, and would recommend it to others. The tenant did not have any suggestions for improvement. The tenant was observed walking without assistance from his/her bedroom, with a wheeled walker, to the living room where he/she sat down in a recliner.

The incident was reported appropriately to the department and an incident report was completed related to the incident.

- Regulatory Insufficiency: None noted.

Dated this 24th day of May, 2011.