IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

Incident Intake #: 33873-I

May 25, 2011

Michelle Migliore, Director
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

RE: Final Incident Investigation Report – Senior Star at Elmore Place, Davenport, IA

Dear Ms. Migliore:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of May 18, 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 #: 33873-I**

Michelle Migliore, RN Director of Assisted Living
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

Date of Incident Investigation:

May 18, 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 Senior Star at Elmore Place on May 18, 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:	59
Current number of tenants with cognitive disorder:	0
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 received regulatory insufficiencies in the areas of: Occupancy Agreement, Service Plan, Nurse Review, Food Service, Staffing, Transportation, Activities, Structural Requirements, Record Checks and Other during 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 staff heard yelling and found a tenant on the floor in the bedroom. The tenant did not activate the personal help button to call for assistance. The program reported the tenant sustained a left hip fracture.

- Monitoring Observation: Tenant #1, an 89 year old, was admitted on 8-28-09 and diagnoses include: Dementia, Hyperlipidemia, Coronary Artery Disease (CAD), Vitamin D Deficiency, Hypothyroidism, Diabetes Mellitus (DM), History of Dizziness, Hearing Loss and History of Urinary Tract Infection (UTI). The tenant was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. At the time of the incident the tenant received Hospice services. The tenant was discharged on 4-25-11. The tenant's service plan indicated staff were to remind the tenant and Tenant #2, the tenant's spouse, to utilize the button when the tenant needed assistance with transfers and mobility. The service plan indicated staff assisted the tenant with mobility including escorts and stand by assistance (SBA). Tenant #2 assisted Tenant #1 with pushing the tenant's wheelchair back and forth to meals. The service plan indicated the tenant required assistance of one to complete transfers safely and staff were to assist with transfers from bed, chair, wheelchair and toilet. The service plan indicated the tenant was an intermittent two person transfer related to level of fatigue.

  According to an Incident/Accident Report, on 4-25-11 at 3:10 p.m. Tenant #2 assisted Tenant #1 out of bed and the tenant fell between bed and side table. Tenant #2 called for help and staff entered the apartment.

Tenant #1 had a 2 cm laceration on the left posterior cranial and left hip pain with shortening and rotation to the left lower extremity (LLE). The tenant's doctor and Hospice were notified. The tenant was transported by emergency medical services (EMS) to a local hospital.

Staff #1, a registered nurse (RN) and the Assistant Director of Assisted Living, was involved with the incident. She was interviewed and provided a written summary of the event. She indicated on 4-25-11 at approximately 3:09 p.m. she was in the hallway with another staff when she heard someone yelling for help. They entered Tenant #1's apartment at 3:10 p.m. and found him/her on the floor in the bedroom with Tenant #2 next to the tenant. Tenant #2 reported he/she had tried to get Tenant #1 out of bed. Tenant #2 reported Tenant #1 had his/her head on the side table. The tenant was found on the floor with his/her head near side table sitting upright. She assessed the tenant for cervical injury and the tenant verbalized he/she wanted to get up. She checked for crepitus at the base of the head and neck and the tenant used full range of motion (ROM) of head and neck without numbness or tingling to bilateral upper extremities. The tenant was assessed for lower extremity injury and the tenant denied pain to lower extremities while on floor and was able to move toes on bilateral feet when asked. The tenant was assisted to the bed by three staff with the tenant not placing any pressure on the left lower extremity. Cranial assessed on posterior region and a 2 cm in width laceration was observed with a small amount of bloody drainage. The left cranial laceration was cleaned with gauze and pressure was held till EMS arrived. The tenant complained of left lower extremity pain and she noticed left lower extremity shortening and rotation. She asked the tenant if he/she could move the left lower extremity and the tenant was not able to move the extremity. The tenant's hip was palpated and the tenant had complaints of pain in left hip area. The EMS was called at 3:14 p.m. and she and other staff stayed with the tenant until they arrived. The EMS and local fire department arrived at 3:20 p.m. The tenant was taken to a local hospital. She was not aware of any other falls the tenant had with injury. She 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 Director, an RN, was interviewed and stated she was in the office with the door open and heard Tenant #2 yelling for help. She went to the apartment and Tenant #1 was on the floor. The tenant was in a seated position and the tenant's back was against the night stand. Staff #1 applied pressure to the tenant's head and the tenant yelled to get him/her off the floor. The tenant did not have any pain except head pain and wiggled his/her toes. The tenant answered yes and no questions appropriately. Three staff sat the tenant on the side of the bed. The tenant complained of his/her leg hurting and leg rotation was observed. The tenant's family and 911 was called. The tenant was sent out to a local hospital. She called the emergency room (ER) at approximately 5:30 p.m. and talked to the nurse and they were waiting for x-ray results. The next morning the Case Manager called and the hip pinning was done early morning. On 4-28-11 the tenant's family reported the tenant had stopped eating and asked about getting Hospice in the hospital. On 5-2-11 family reported the tenant died. She stated the situation was handled appropriately and the tenant did not have any other falls with injuries. She 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.

Tenant #2, the tenant's spouse was interviewed. He/she stated nursing services were available and staff treated him/her great. Staff were trained to provide the services needed and they knew what services to provide. He/she stated they had as much staff as they have room for and the staff were very good to his/her spouse. The tenant stated he/she felt like staff were standing outside the door every time he/she pushed the button and needed help. Staff always responded immediately and he/she said just to ask and staff helped with whatever was needed. The tenant felt safe and was satisfied with the program.

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

- Regulatory Insufficiency: None noted.

Dated this 26th day of May, 2011.