IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 34089-I

June 10, 2011

Christina Bricker, Housing Director
Summit Pointe Senior Living
3505 English Glen Avenue
Marion, IA 52302

RE: Final Incident Investigation Report – Summit Pointe Senior Living, Marion, IA

Dear Ms. Bricker:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of May 31, 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 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Incident Intake #: 34089-I

Christina Bricker, Housing Director
Summit Pointe Senior Living
3505 English Glen Avenue
Marion, IA 52302

Date of Incident Investigation:

May 31, 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 Summit Pointe Senior Living on May 31, 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:	86
Current number of tenants with cognitive disorder:	7
Total Population of GPP:	93

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

Total Population of DSP:	13
Total Census of ALP:	106

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

Program History –

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

A. Other

Incident Allegation: The program reported staff responded to a tenant's call light to assist the tenant to the bathroom and escort the tenant to supper. The tenant was sitting in a lift chair when staff arrived to assist. A walker was directly in front of the tenant and a wheelchair was in front of the walker. As the aide moved the tenant's wheelchair out of the way, the tenant put the lift chair in the upright position. In the time it took to move the wheelchair and turn around, the tenant stood up without waiting for assistance and fell sideways onto the floor. The tenant sustained a left hip fracture.

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 2-5-07 and diagnoses include: Hypertension (HTN), Anxiety, Deep Vein Thrombosis (DVT), Status Post (S/P) Hysterectomy (1999), S/P Post Brain Stem Cardiovascular Accident (March 2006) and Parkinson's Disease. According to the Cognitive Ability Assessment the tenant was scored at a low risk. The service plan indicated the tenant had been instructed to call for assistance with transfers and when he/she needed to use the bathroom. Once in his/her wheelchair the tenant could self propel around the apartment or in the halls. The service plan indicated the tenant had a history of falls due to poor balance. The service plan listed interventions that included the tenant was to call for assistance with all transfers, apartment floor was to be clear of clutter and area rugs, the pendant was to be worn at all times, walker to be used during ambulation, and tenant reminders to set brakes on wheelchair before transferring. The service plan also indicated staff would provide stand by assistance (SBA) with a

gait belt and walker. The wheelchair would be taken along so tenant could sit down when tired or destination was reached. The tenant had requested to walk with staff assistance from his/her apartment to the second floor nurses' station on his/her way to meals before sitting in the wheelchair. The walker could be left at the nurses' station and staff would continue to escort the tenant to meals in their wheelchair.

According to a Resident Occurrence Report, on 5-5-11 at 4:04 p.m. the tenant had lifted the recliner to the highest position, with the walker in front of him/her while the Certified Nurses Aide (CNA) moved the wheelchair out of the way when the tenant fell sideways. The tenant attempted to sit up. The left leg was rotated outwardly and the tenant complained of pain. A call was made to 911 and the tenant was transported to a local hospital, according to the report.

Tenant #1's file was reviewed. According to the Service Notes dated 5-5-11, the nurse was called into the room by a CNA. The tenant presented on the floor, lying on his/her left side. The lift chair was in the high position with a walker in front of the chair. Per the staff and tenant report, the CNA had moved the wheelchair out of the way so that the tenant could stand using the walker, which was the tenant's normal routine. As the CNA moved the wheelchair, the tenant proceeded to raise the lift chair to the standing position, with the walker held, the tenant fell over sideways. Vital signs were taken and the tenant's face was pink. The nurse asked if anything hurt and the tenant replied that his/her left hip hurt. The tenant attempted to sit up while staff noted that the left leg rotated distally, and quickly assisted the tenant back down on the floor, and placed a pillow under the tenant's head. A phone call was made to the tenant's family and 911. The tenant was stabilized and lifted to a gurney and transported via ambulance to a local hospital. At the time of the investigation, the tenant was at a skilled nursing facility (SNF).

Staff #1 stated every day at 4:00 p.m., Tenant #1 called for assistance to go to dinner. On 5-5-11, she went into the tenant's room to take the tenant to the bathroom. The tenant's walker and wheelchair were in front of the tenant. While Staff #1 moved the wheelchair, the tenant raised the recliner. The tenant then grabbed the walker and fell onto his/her left side. Staff #1 had a trainee (Staff #2) with her who was standing in the kitchen. Staff #1 attempted to call the nurse with her phone and when there was no answer, sent Staff #2 to the nurse's office. The nurse came in and checked the tenant's vital signs and asked the tenant if he/she was in pain. The tenant replied that he/she was in pain so staff kept the tenant comfortable. The nurse called the tenant's family and then tried to assist the tenant to a seated position when she noticed the left leg was rotated out so the tenant was laid her back down and a call was placed to 911.

The nurse stated when she was notified Tenant #1 had fallen, she ran to the apartment and found the recliner in the upright position with the walker and wheelchair in front of the recliner. The tenant was on the floor on his/her left side. She checked the tenant's vitals and then asked Staff #1 what happened. Staff #1 told her she had responded to the call light to assist the tenant to the toilet. Staff #2 was in the kitchen. Staff #1 was in the process of moving the wheelchair when the tenant raised the recliner and stood up, reached for the walker, and lost his/her balance and fell. The nurse asked the tenant if anything hurt. The tenant stated he/she did not think anything hurt, so the nurse started to sit the tenant up. At the same time the nurse saw the left leg was distally rotated so she had the tenant lay back down and placed a

pillow under the tenant's head. The nurse called 911 and the tenant's family. The emergency personnel arrived, stabilized the leg and took the tenant in the ambulance.

Staff #1 and the nurse reported there were enough staff to meet the needs of the tenants and tenants received good care. Staff #1 and the nurse reported no tenants exceeded the appropriate level of care.

The call light history was reviewed related to the incident. The history indicated the tenant called for assistance at 3:58 p.m. and was answered at 4:01 p.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 10th day of June, 2011.