IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 36939-I

January 5, 2012

Ms. Brenda Cook, Director
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

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

Dear Ms. Cook:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 20 & 21, 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

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IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Brenda Cook, Assisted Living Director
Senior Star at Elmore Place
4500 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 36939-I

Date of Complaint/Incident Investigation:

December 20 & 21, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	66
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	67
TOTAL census of Assisted Living Program	67

Program History – There were substantiated Regulatory Insufficiencies found during this certification period for Service Plan, Medications and Nurse Review.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Other

Complaint/Incident Allegation: The program reported staff responded to a personal help button and found a tenant who started to fall out of a recliner. The program reported the tenant sustained a left hip fracture.

- Monitoring Observation: Tenant #1, an 82 year-old, was admitted on 10-7-11 with diagnoses of Osteoarthritis of the Knees, Cardiovascular Accident, Nodule on Lungs, Atherosclerotic Heart Disease, Hypertension, Gastric Esophageal Reflux Disease and Paralysis of the Right Hip. Tenant #1 received home health services and was discharged from home health on 12-13-11. According to the Program's Move-Out Report, Tenant #1 was notified on 12-13-11 that he/she no longer met the Program's criteria for retention. Tenant #1 resided at a rehabilitation center at the time of the investigation.

  According to an Incident Report Form, on 11-13-11 at 11:15 a.m., Tenant #1 used the personal help button to call for assistance. Tenant #1 was in a recliner and suspended with his/her bottom six inches in the air with left arm on the recliner and right arm on a table. Tenant #1 denied hitting his/her head and denied any pain. Tenant #1 was assisted to a standing position with the assistance of three staff and was able to move all extremities and did not have any internal or external rotation.

  The service plan indicated Tenant #1 required the assistance of one person to transfer from bed, chair, wheelchair and toilet. Tenant #1 could stand, and supported ones' own weight and could pivot.

The service plan identified Tenant #1 as a fall risk; indicated staff would assist Tenant #1 with mobility and transfers and encourage Tenant #1 to use the personal help button before getting up. Tenant #1 would have frequent rounds every two hours for safety and fall risk. According to Nurse's Notes dated 11-13-11 at 11:45 a.m., Tenant #1 was able to move extremities. Tenant #1's family member and the Director of Nursing were notified of the incident and the physician was faxed. According to the Nurse's Notes on 11-13-11 at 6:00 p.m., Tenant #1 denied pain or discomfort and was unable to stand or transfer without the assistance of two and was unable to bear weight or stand. On 11-14-11, Tenant #1complained of pain in the left hip and the physician was notified. An order was received for a left hip x-ray. Tenant #1's family member took Tenant #1 to see the physician and have the x-ray performed. A Nurse Review was completed on 11-14-11 at 9:00 a.m. in regards to the incident on 11-13-11 and indicated no apparent injuries at the time of the incident but Tenant #1 now complained of left hip pain upon standing. The documentation reflected there was no shortening or internal rotation noted. On 11-14-11 at 2:40 p.m., Tenant #1's family member informed the Program that Tenant #1 was admitted to the hospital with a left hip fracture. According to the Nurse's Notes dated 11-15-11, Tenant #1's x-ray revealed a left impacted sub capital femoral neck fracture and surgery was performed on 11-14-11.

Staff Member #1, a licensed practical nurse, was interviewed. She worked the first shift at the time of the incident. Tenant #1 pushed the personal help button and two care partners responded to the call and then paged her. When she arrived Tenant #1 was in an electric recliner with elbows on the chair arms and feet on the floor. The care partners had assisted Tenant #1 into the electric recliner. Tenant #1 denied any pain and just wanted to go to the bathroom. Tenant #1 was transferred to a power wheelchair and assisted to the bathroom. Staff Member #1 notified Tenant #1's family member who reported recent problems with the chair and didn't think his/her family member was using the chair appropriately and had considered getting a different chair. Later Tenant #1's Physical Therapist notified Staff #1 that after Tenant #1's treatment, Tenant #1 grimaced sometimes during exercises but no internal or external rotation was noted. The Physical Therapist recommended Tenant #1 have x-rays. Staff Member #1 notified the nurse on call, the family member and faxed the physician regarding the incident and completed an incident report.

The Assistant Director of Nursing stated Tenant #1 originally lived in independent housing and was transferred to the Program because of increased care needs. Tenant #1 started physical therapy services at approximately the same time as admission to the Program. She stated Tenant #1 did not have a history of falls prior to this incident. She stated she completed the self report within 24 hours of becoming aware of Tenant #1's fracture.

The Assisted Living Director stated staff alerted her of Tenant #1's incident via a phone call. She informed staff to complete an incident report and to continue to monitor Tenant #1. She stated the incident was handled appropriately and anytime an incident occurs, staff is to call the nurse to inform her so she can assess the situation. She stated the Assistant Director of Nursing completed the on-line self report.

She also stated Tenant #1 was currently at a rehabilitation center for therapy and was not sure if Tenant #1 would return to the Program.

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

- Regulatory Insufficiency: None noted.