IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38011-I

April 2, 2012

Mr. Kent Walton, Administrator
Chris DeVore, Director
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233

RE: Final Complaint/Incident Investigation Report – Promise House, Hiawatha, IA

Dear Mr. Walton:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 27, 2012, 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 Complaint/Incident Investigation Report

Assisted Living Program:

Complaint/Incident Intake #: 38011-I

Kent Walton, Administrator
Chris DeVore, Director
Promise House
1320 Litchfield Drive
Hiawatha, IA 52233

Date of Complaint/Incident Investigation:

March 27, 2012

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	19
Total Population of Program at time of on-site	19
TOTAL census of Assisted Living Program	19

Program History – The program received a regulatory insufficiency in the area of service plan during the Recertification and Incident Investigation (32765-I) of February 8, 2011.

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

A. Other

Complaint/Incident Allegation: The Program reported a tenant fell and had a hip fracture. It was reported the tenant had a fall history and used bed/chair alarms.

- Monitoring Observation: Tenant #1, a 97 year old, was admitted on 10-20-11 and diagnoses include: Dementia, Arthritis, Osteoporosis, Hypothyroidism, History of Urinary Tract Infection, Right Pelvic Fracture, Prolapsed Bladder and Pancytopenia. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 was discharged on 2-6-12 and died on 2-8-12.

  The service plan indicated Tenant #1 ambulated with assist of one with a wheeled walker. Staff was to cue/redirect as needed if Tenant #1 was seen getting up on his/her own. A history of frequent falls and use of bed and chair alarms were reflected on the service plan. The service plan also indicated Tenant #1 was unaware of safety limitations and Tenant #1 was monitored closely since he/she did not consistently report needs. Staff was to attempt to redirect when Tenant #1 got up unassisted and was to anticipate his/her needs to maintain safety, according to the service plan.

  According to an Occurrence Report on 2-4-12 at 4:40 a.m. staff heard an alarm and immediately responded to the apartment. Upon entering the apartment staff found Tenant #1 on the floor laying on his/her right side by the bed with the walker on his/her legs. Tenant #1 reported right hip pain. Tenant #1 was made as comfortable as possible, was covered with a blanket and a small pillow was placed under his/her

head. Staff stayed with Tenant #1 and the Director was notified. Tenant #1's family and physician were notified and an ambulance was called.

According to the Department's Facility Investigation Report Form, on 2-4-12 at 4:40 a.m. staff heard the bed alarm sounding and immediately went to the room. Tenant #1 was found laying on his/her right side on the floor beside the bed with the walker on his/her legs. Tenant #1 reported right hip pain. Tenant #1 was made comfortable and staff stayed with Tenant #1. Staff reported Tenant #1 was checked at 4:35 a.m. and was in bed with the bed alarm in place. Tenant #1 was transferred to a local hospital for evaluation of right hip pain. The diagnosis was right hip fracture and Tenant #1 was admitted to the local hospital for observation. Tenant #1's family spoke with the physician and did not want surgery. Tenant #1 was transferred to a care center on 2-6-12.

Nurse's Notes dated 2-4-12, indicated the Director received a call from staff and it was reported staff had opened Tenant #1's door at 4:35 a.m. and he/she was in bed and checked at that time. Staff reported the bed alarm sounded at 4:40 a.m. and staff immediately went to the apartment. Tenant #1 was found on the floor laying on his/her right side by the bed with the walker on his/her legs. Tenant #1 reported right hip pain. The Director was informed a staff member was sitting with Tenant #1. The Director instructed staff to call Tenant #1's family and the Director called Tenant #1's physician. Staff reported Tenant #1's blood pressure was 100/65 and he/she refused to have pulse taken. An order was received to transfer to a local hospital for evaluation of the right hip. Tenant #1 was taken to a local hospital via ambulance. According to Nurse's Notes, Tenant #1was diagnosed with a right hip fracture.

Staff #1 stated she was in the day area when she heard the bed alarm go off in Tenant #1's room. The door was open; she turned on the light and saw Tenant #1 on the floor on his/her right side with the walker on top of his/her legs. Staff #1 did not move Tenant #1. Staff #1 got down on the floor and asked Tenant #1 where the pain was and Tenant #1 responded it was his/her right hip. Tenant #1 was cold so Staff #1 covered him/her with a blanket. Staff #1 called the Director and was told to check Tenant #1's vitals. Staff #1 kept talking with Tenant #1 and placed a small pillow under his/her head. Staff #1 stayed on the phone with the Director until the ambulance arrived. She stated the Director called the physician, the ambulance and Tenant #1's personal caregiver.

Staff #1 stated she last checked on Tenant #1 around 4:15 a.m. and Tenant #1 was asleep in bed. Staff #1 stated the bed alarm did sound and it was a loud beep. She responded to the alarm within 30 seconds. Tenant #1 used a walker but sometimes would forget to use it. Staff #1 stated Tenant #1 was not consistent when asking for help, so a bed alarm was used.

The Director stated staff called her to say they found Tenant #1 on the floor. She spoke with Staff #1 via a telephone until the ambulance arrived. Staff had checked on Tenant #1 a few minutes before the bed alarm went off. Staff #1 had just made rounds and Tenant #1 was sleeping. The Director said she was told the bed alarm sounded and staff responded immediately. Tenant #1 used a wheeled walker and moved quickly, according to the Director.

Staff #1 and the Director stated the situation was handled appropriately. The Director stated staff was good at calling her, she gave them her input and if needed she came into the Program.

The Department was notified on 2-6-12, which was the next business day after the incident. An incident report was completed related to the incident. The service plan reflected interventions related to falls and a history of falls. At the time of the incident the bed alarm functioned and staff responded to the alarm. The Director, Tenant #1's family and physician were notified of the incident.

- Regulatory Insufficiency: None noted.