IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

**Complaint/Incident Intake #: 38129-C**

April 11, 2012

Ms. Terri Cosselman, Administrator
Apple Valley Assisted Living
405 27th Avenue South
Clear Lake, IA 50428

**RE: Final Complaint/Incident Investigation Report – Apple Valley Assisted Living, Clear Lake, IA**

Dear Ms. Cosselman:

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 #:** 38129-C

Terri Cosselman, Administrator
Apple Valley Assisted Living
405 27th Avenue South
Clear Lake, IA 50428

**Date of Complaint/Incident Investigation:**

March 27th, 2012

**Monitor(s):**

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN

**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: | 55 |
| Number of tenants with cognitive disorder: | 0 |
| Total Population of Program at time of on-site | 55 |
| **TOTAL census of Assisted Living Program** | 55 |

**Program History** – The program did not receive any regulatory insufficiencies during this certification period.

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

**A. Staffing**

Complaint/Incident Allegation: A tenant fell and didn't go to the hospital emergency room because the nurse told the tenant he/she was okay. The tenant was later transported to a local hospital emergency room for evaluation. The tenant was treated for broken ribs, a punctured lung and now resides in a nursing facility.

- Monitoring Observation: Three tenant files were reviewed. Files for Tenants #1 and #3 were reviewed and indicated no concerns.

  Tenant #2, an 84 year-old, was admitted on 1-22-10 and had diagnoses of: Hypertension, Osteoporosis, Depression, Osteoarthritis, History of Fractured Pelvis and Ribs, Anemia, Pneumonia, Chronic Obstructive Pulmonary Disease and Atrial Fibrillation. A mental status questionnaire was completed on 9-9-11 and indicated no cognitive impairment.

  Tenant #2's service plan of 1-19-11 indicated Tenant #2 was independent with ambulation, but used a walker to assist. Tenant #2 was hospitalized on 6-25-11 for a broken pelvis and fractured ribs related to a fall of the same day. On 7-3-11 Tenant #2 was discharged and transferred to a skilled nursing facility. On 9-9-11 Tenant #2 was discharged from the nursing facility and returned to the Program. Nursing facility discharge instructions for care indicated Tenant #2 was independent with ambulation and used a walker to assist. Functional, cognitive and health evaluations were completed on 9-9-11 and a service plan was updated and indicated Tenant #2 needed assistance with activities of daily living, including assistance with dressing, bathing, medication administration, but was independent with ambulation with the use a walker.

Resident service notes of 12-6-11 indicated a 90-day nurse review was completed. The nurse review indicated Tenant #2 was up ad lib with the use of a front wheeled walker, gait was steady and denied pain. Functional and health evaluations were completed at the same time and revealed no change in health and functional status. The service plan was updated, noting no change in service provided and the service plan had been signed by Tenant #2.

Resident service notes of 2-17-12 indicated the Program nurse reported Tenant #2 had pushed his/her pendent at 4:45 p.m., calling for assistance. Tenant #2 was found sitting on the floor behind a chair. Tenant #2 stated he/she had fallen and hit the side of the chair. Tenant #2 reported he/she didn't remember what caused him/her to fall. Tenant #2 reported his/her right side was hurting and a red area was seen on the right side of the Tenant #2's back. The Program nurse completed a nurse review, felt the ribs and back and no bumps were felt. Tenant #2 didn't complain of any other pain. Tenant #2 was assisted to the chair and Tylenol was given. Tenant #2 refused to go to the hospital and didn't want his/her physician contacted. Tenant #2 requested supper in his/her room. The Program nurse directed staff to check Tenant #2 frequently during the night, every one to two hours.

An incident report of 2-17-12 at 4:45 p.m. confirmed what had been written in the resident service notes of the same date and time. The incident report indicated Tenant #2 refused to have Tenant #2's physician contacted and refused to be taken to the hospital.

Resident service notes of 2-17-12 at 5:20 p.m. indicated the Program nurse checked on Tenant #2. Tenant #2 was eating his/her meal and voiced no complaints of shortness of breath and reported the Tylenol given earlier had helped. Program staff would continue to monitor.

Six staff members were interviewed. Staff #1, #2 and #3 reported they had no first hand information related to the falls of 2-17-12 and 2-18-12. Staff #4 reported she had worked the evening of 2-17-12 from 3:00 p.m. until 11:00 p.m. She reported she responded to Tenant #2's call for assistance. Staff #4 entered Tenant #2's apartment and found the pendent used for calling for assistance was on a table in Tenant #2's apartment. Staff #4 was followed by the Program nurse and the Administrator. The Program nurse checked Tenant #2's ribs and back, as Tenant #2 landed on his/her side and reported his/her ribs were sore. Tenant #2 reported he/she didn't remember falling. Tenant #2's walker had been close by. Tenant #2 reported he/she had a little bit of rib pain. The Program nurse completed an assessment. Both she and the Program nurse talked with Tenant #2 to make sure he/she was okay. Staff #4 and the Program nurse helped Tenant #2 up and to a chair. Tenant #2 reported he/she was doing well. Tylenol was given and a supper room tray. Staff #4 reported she checked on Tenant #2 every hour and reported Tenant #2 was doing fine. Staff #4 didn't notice any changes to breathing, color or mental status changes. Staff #4 gave report to the night staff, Staff #5, which included the need to complete hourly checks.

Staff #5 reported she had checked on Tenant #2 every one-to one and a half hours throughout the night. At 5:00 a.m. she assisted Tenant #2 with compression stockings and Tenant #2 walked by himself/herself to the bathroom and back to his/her bedroom. Staff #5 reported Tenant #2 had a history of knee pain but didn't recall

when Tenant #2 had any other falls. Tenant #2 ambulated independently with the use a walker. The Program nurse directed staff to keep an eye on Tenant #2. Staff #5 reported she left before Tenant #2 went to breakfast.

Resident service notes of 2-18-12 at 11:30 a.m. indicated the Program nurse was notified Tenant #2 had fallen and had to crawl to get his/her pendent, as Tenant #2 wasn't wearing it. Tenant #2 complained of pain on the right side. Vital signs were taken – Temperature was 98.2F, pulse was 88 beats per minute, 26 respirations per minute and blood pressure was 160/72. No shortness of breath or light headiness noted. Tenant #2 reported his/her legs wouldn't hold him/her up. Staff assisted Tenant to a chair. Resident notes of the same entry reported an ambulance was called, family was called and Tenant #2 was transported to a hospital emergency room. Resident service notes of 2-18-12 indicated Tenant #2 was admitted to the hospital for broken ribs, had a punctured lung and while hospitalized had a Myocardial Infarction.

An incident report of 2-18-12 confirmed what had been written in the resident service notes of the same date and time. The incident report indicated Tenant #2's family member was called and Tenant #2 was taken by ambulance to a hospital emergency room for evaluation and treatment.

Staff #6 was interviewed and reported he had worked 7:00 a.m. until 3:00 p.m. He had been given report Tenant #2 had fallen, was checked on and had done well throughout the night. Staff #6 reported he had not been instructed on completing one hour checks but was to check on Tenant #2. At 8:30 a.m. Tenant #2 was sitting in a chair and did not appear to have anything wrong. No shortness of breath and was mentally fine. Tenant #2 reported he/she felt weak and wanted to eat breakfast in his/her room. Staff #6 offered to assist Tenant #2 to the noon meal. Approximately 11:25 a.m. he went to Tenant #2's room and found another staff member with Tenant #2. Tenant #2 was on the floor and wanted to get up. Staff #7 called the Program nurse who gave staff direction to comfort Tenant #2 and call for an ambulance. Ambulance staff arrived and Tenant #2 complained of pain and reported the pain could have been from the night before.

Staff #7 was interviewed and reported she worked 7:00a.m.until 3:00 p.m. Night shift had reported Tenant #2 had fallen, but was doing okay. Night staff had reported to keep an eye on Tenant #2 but gave no specific times for checking Tenant #2. Between 9:45 a.m. and 10:15 a.m. Staff #7 stopped to check in on Tenant #2 and found him/her sitting in a chair. No shortness of breath was noted, color was fine, no mental status changes and no complaints of pain. Approximately 11:20 a.m. Tenant #2 had turned on his/her call light. Staff #7 arrived at Tenant #2's apartment and found Tenant #2 on the floor. Staff #7 called the Program nurse, who directed staff to complete vital signs. Staff #7 noted no shortness of breath but Tenant had pain from falling. Staff #7 called an ambulance and Tenant #2 was transported to a hospital emergency room for evaluation and treatment.

Staff #4, who worked the evening shift on 2-17-12, reported she completed one hour checks. Staff #5, who worked the night shift, reported she completed checks on Tenant #2 every one and half hours, as directed by the nurse. Staff #6 reported she

checked on Tenant #2 at 8:30 a.m. Staff #7 reported he had checked on Tenant #2 sometime between 9:45 a.m. and 10:15 a.m.

- Regulatory Insufficiency: None noted.