IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 39960-M
39963-C

August 13, 2012

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

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

Dear Ms. Bricker:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 25, 26 & August 7, 8, 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 or **Rose.Boccella@dia.iowa.gov**

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 #:** 39960-M, 39963-C

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

Date of Complaint/Incident Investigation:

July 25, 26 & August 7, 8, 2012

Monitor(s):

Maribeth Freland, RN
Joyce Kix, RN
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:	90
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	98
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	110

Program History –

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

A. Other

Incident Allegation #39960-M: The Program reported to the Department a tenant fell and sustained a major injury resulting in death.

Complaint Allegation #39963-C: It was alleged a tenant did not receive appropriate care following an incident.

- Monitoring Observation: Four tenant files were reviewed.

  The monitor reviewed incident reports from the previous three months. The Program identified Tenant #1, #2, #3 and #4 had falls with injury.

  According to a Resident Occurrence Report dated 6-3-12, Tenant #1 fell off the bed, hitting head on a walker and was transported to the hospital. Tenant #1 returned with two staples to the laceration. The Program completed an incident report and contacted the physician and family. The Program responded to the fall with injury appropriately.

Tenant #2, an 83 year old, was admitted on 11-19-11 and diagnoses include: Status Post Right Shoulder Arthroplasty, Diabetes Mellitus, Depression, Hypertension, History of Cardiovascular Accident in 2009 and Bilateral Pedal Edema, Fracture of the Right Foot. Tenant #2 was staged at a two on the Global Deterioration Scale which indicated very mild cognitive decline.

According to a Resident Occurrence Report dated 7-15-12, Tenant #2 was found on the floor by the bed by Staff #1. Tenant #2 reported dizziness while heading to the bathroom and fell. Staff #1 called Staff #2 and the on call nurse. Staff #1 saw on Tenant #2's left eye a huge bump that looked like blood was inside. Staff #1 also noticed the cheek bone was starting to swell. Tenant #2 said the right wrist was sore. Staff #1 and #2 assisted Tenant #2 into bed, gave Tenant #2 an ice bag and then checked 30 minutes later.

According to Service Notes completed on 7-16-12, on 7-15-12 around 2:20 a.m., staff responded to Tenant #2's call light and observed Tenant #2 on the floor at the foot of the bed. Tenant #2 reported he/she got up to use the bathroom and became dizzy which resulted in the fall. Tenant #2 was able to recall the events and was alert and oriented. Staff observed a lump over Tenant #2's left eye and swelling of left cheek bone. Tenant #2 complained of pain in right wrist and knee but was able to move all extremities without difficulty. Vital signs were checked: BP 178/38, Pulse 70, Respirations 18 and Temperature 98.1. Staff suggested Tenant #2 be evaluated in the Emergency Room (ER) but Tenant #2 refused, just wanted help getting back into bed with the assistance of two. Tenant #2 was able to stand and bear weight. The nurse was notified and advised Tenant #2 should go to the ER. The Tenant refused. An ice pack was applied to left cheek and eye and the nurse instructed Staff #1 to check on Tenant #2 every half hour and report any changes.

According to an interview with Staff #1, she responded to a pendant call for Tenant #2 at 2:10 a.m. When entering the room she found Tenant #2 on the floor lying on her left arm with feet towards the bathroom. Staff #1 asked what happened and Tenant #2 said he/she felt dizzy and had to go to the bathroom so got up and fell. Staff #1 asked if anything hurt and Tenant #2 said no. Staff #1 called Staff #2 to assist Tenant #2 back to bed. Staff #1 noticed a slight bump the size of a golf ball on Tenant #2's forehead and bruises on left cheek below the eye and on right and left forearms. Tenant #2 said he/she took Coumadin and often got bruises. Staff #1 called the on call nurse, reported the vital signs and was directed by the nurse to put ice on the bump and pass along the information in report. Staff #1 was also told to check on Tenant #2 every 30 minutes. At the same time, Staff #2 was telling Tenant #2 to go to the hospital. Tenant #2 said no and just wanted to go back to bed to sleep. Around 3:20 a.m. Staff #1 checked on Tenant #2 who was sitting up in bed, with one leg on the floor holding the ice pack. Staff #1 saw blood on the ice bag about the size of a dollar bill spread out, stated it was not a lot of blood. The blood was dripping from the nose. Staff #1 told Tenant #2 to sit with the head tilted back and Staff #1 raised the head of the bed. Staff #1 said Tenant #2 activated the call light around 4:07 a.m. and she found Tenant #2 holding a towel with bloody snot. Tenant #2 was coughing and hacking but nothing was coming up. When Staff #1 checked Tenant #2 at 5:15 a.m. Tenant #2 was sleeping. Staff #1 nudged Tenant #2 and asked if Tenant #2 felt okay. Tenant #2 responded, was groggy and no bleeding was noted. The towel was clean. Tenant #2 was checked on again at 5:55 a.m. and was asleep. Staff

#1 asked if Tenant #2 needed anything and Tenant #2 responded and then went back to sleep.

Staff #1 met with Staff #3 who was coming onto the day shift. Staff #1 told Staff #3 Tenant #2 had fallen and messed up the eye, stating Staff #1 had never seen anything like this before. Staff #1 instructed Staff #3 to check on Tenant #2: however, did not advise oncoming staff to check the tenant every 30 minutes. Staff #1 informed Staff #3 she had documented the incident on the 24 hour sheet. At approximately 6:20 a.m., Staff #1 checked on Tenant #2 and asked if Tenant #2 was okay. Tenant #2 responded yes but tired. Staff #1 checked on Tenant #2 again at 7:05 a.m. and asked Tenant #2 if Tenant #2 needed anything. It was light in the room and the staff member did not observe any active bleeding. Tenant #2 responded no. Staff #1 instructed Tenant #2 to push the pendant if anything was needed.

In an interview with Staff #3, she said she came to work at 6:00 a.m. and it was reported that Tenant #2 had fallen, was throwing up blood, had a hematoma and a huge purple area above the left eye. Staff #3 said Tenant #2 was independent and usually did not go to the dining room for breakfast. She entered Tenant #2's room at approximately 9:00 a.m. and found Tenant #2 lying on the bed with a housecoat on. Staff #3 saw dried blood on the front chest and shoulder area of the housecoat. There was no blood on Tenant #2's body, only on the housecoat. Staff #3 touched Tenant #2's arm and leg and called out Tenant #2's name. Tenant #2 did not respond. Staff #3 called the nurse and explained Tenant #2 was nonresponsive, not waking up and had pursed breathing. The nurse directed Staff #3 to call 911. Ambulance transport was called and Tenant #2 was transported to the ER. Tenant #2's family member and the physician were contacted. According to the Service Notes, Tenant #2 was admitted to the hospital with a diagnosis of Intracranial Bleed. Tenant #2 expired at the hospital on 7-16-12.

According to the Service Plan completed on 3-13-12, Tenant #2 was independent in all personal and health related cares, including self administration of medications. Tenant #2's file included a Do Not Resuscitate document signed by Tenant #2 on 9-12-11 and Tenant #2's physician on 11-17-11.

A review of pendant calls showed Tenant #2 activated the pendant at 2:09:49 a.m. on 7-15-12 and the alarm was cleared at 2:13:39 a.m. The time lapsed was 3 minutes and 49 seconds. The pendant alarmed again at 4:00:02 a.m. and cleared at 4:01:17 a.m. The time lapsed was 1 minute and 14 seconds. Tenant #2 activated the pendant at 4:10:46 a.m. and the alarm was cleared at 4:11:56 a.m. The time lapsed was 1 minute and 9 seconds. A review of pull cords activated on 7-15-12 did not reflect any activation by Tenant #2. An incident report was completed related to Tenant #2's incident and the Department was notified of the incident appropriately.

According to a Resident Occurrence Report dated 7-13-12, Tenant #3 fell and hit head. Tenant #3 was transported to the hospital and returned with a diagnosis of having had a fainting spell. The Program completed an incident report and contacted the physician and family. The Program responded to the fall with injury appropriately.

According to a Resident Occurrence Report dated 7-3-12, Tenant #4 fell and complained of pain on right side of back and left hip. Tenant #4 was transported to the hospital and was admitted for therapy. The Program completed an incident report and contacted the physician and family. The Program responded to the fall with injury appropriately.

Review of Tenant #1, #2, #3 and #4's files, review of incident reports for three months and staff interviews reflected appropriate cares were provided following an incident. Report given to the oncoming shift did not include directions to check on Tenant #2 every 30 minutes as the aide was instructed by the RN. While a deviation from the requirements of the rules was found, it did not meet the standards set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

Regulatory Insufficiency: None noted.