IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 42084-I

January 28, 2013

Mr. Clifford McFerren, Administrator
Reflections Assisted Living
512 13th Street
Wellman, IA 52356

RE: Final Complaint/Incident Investigation Report – Reflections Assisted Living, Wellman, IA

Dear Mr. McFerren:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 16, 2013, 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 #:** 42084-I

Clifford McFerren, Administrator
Reflections Assisted Living
512 13th Street
Wellman, IA 52356

Date of Complaint/Incident Investigation:

January 16, 2013

Monitor(s):

Stephanie Cummins, MA

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:	4
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	9

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. Other

Complaint/Incident Allegation: The Program reported staff heard a tenant calling for help while staff was helping another tenant. The tenant was found on the floor next to the bed. A nurse completed an evaluation, took vitals, notified family and the doctor. The tenant was transferred to a hospital for further evaluation. The tenant sustained a fractured femur and surgery was not elected.

- Monitoring Observation: Two tenant files were reviewed.

  Tenant #1, an 89 year old, was admitted on 2-9-12 and diagnoses included: Vascular Dementia, Dyspnea, Chronic Obstructive Pulmonary Disease, Hypertension, Macular Degeneration, Myasthenia, Fatigue, Sciatica, Ensethopathy and Lumbago. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline.

  The service plan indicated Tenant #1 ambulated independently with a walker. Staff provided stand by assistance with transfers as needed. Tenant #1 was independent with toileting. A Nurse Review dated 10-24-12 indicated on 9-21-12 an order was received for physical therapy (PT) for strengthening and PT was completed on 10-24-12 as Tenant #1 had met goals. A Nurse Review dated 12-4-12, indicated on 11-3-12 Tenant #1 complained of dizziness and on 11-8-12 a new order for Meclizine as needed was received. Review of the December 2012 Medication Administration Record indicated Meclizine 12.5 mg tablet, take one tablet by mouth two times a day as needed (dizziness) was administered five times in December. Meclizine was not administered on 12-21-12 or 12-23-12 when Tenant #1 had falls. Nurse's Notes dated 12-23-12 indicated the companion notified the nurse that Tenant #1 was on the floor. Upon entering the room Tenant #1 was observed lying supine next to the bed

with the head next to the nightstand and feet and legs straight out toward the door to the room. Tenant #1 reported Tenant #1 fell; however, was unable to recall events that lead up to the fall. Hand grasps were equal and Tenant #1 raised the left leg without difficulty. Tenant #1 was unable to lift/move the right leg and external rotation and shortening was noted. The doctor was notified and a telephone order was received to transfer to the emergency room (ER) per ambulance to evaluate and treat. Tenant #1's family was notified and an ambulance was called. Tenant #1 was transferred to the ER and the AL Director was notified. Nurse's Notes dated 12-26-12 indicated upon arrival to the ER on 12-23-12 an x-ray showed a fractured femur and surgery was not elected. Tenant #1 was in the hospital for therapy and pain management. Tenant #1 was discharged from a hospital and admitted to a nursing facility for skilled care.

According to a Tenant Unobserved Incident Report dated 12-23-12 (the companion observation), at around 5:00 a.m. Staff #1 was assisting another tenant to the bathroom and heard Tenant #1 yell for help. Staff #1 found Tenant #1 lying on the floor. Staff #1 called a nurse via portable phone. Staff #1 had last checked Tenant #1 at 4:00 a.m. and Tenant #1 was asleep in bed. The nursing assessment completed by a nurse indicated Tenant #1 was observed lying supine next to the bed with the head near the nightstand and feet and legs were straight toward the door to the room. The walker was next to Tenant #1 in an upright position. Tenant #1 stated Tenant #1 fell; however, was not able to recall the events prior to the fall. Tenant #1 reported Tenant #1 was wet all over two or three times. Grips were equal and neurological checks were within normal limits. Tenant #1 was able to lift the left leg without difficulty but unable to move the right leg. Tenant #1's family was notified and a request was made to transfer Tenant #1 to a hospital.

Tenant #1 had another fall on 12-21-12. According to a Tenant Unobserved Incident Report dated 12-21-12 (the companion observation), Tenant #1 was found sitting on the floor by the bathroom door. Tenant #1 did not know what happened and the walker was by the bed. A nurse was called and came over and checked Tenant #1. Tenant #1 was helped back to bed. The nursing assessment completed by a nurse indicated Tenant #1 was sitting on Tenant #1's buttocks leaning against the bathroom door, the walker was by the head of the bed on the other side of the room. Tenant #1 did not know how Tenant #1 got there. Tenant #1 was able to move all extremities without difficulty or complaints of pain. There was no external rotation or shortening. Tenant #1 was able to ambulate back to bed after assistance back to feet. Tenant #1 complained of pain in knee after lying down but was unable to locate pinpoint location of pain with assessment. No injuries were noted.

Staff #1, a companion, worked at the time of incident. Staff #1 was interviewed. Staff #1 said between 5:15 a.m. to 5:30 a.m. she was completing hourly checks and was about to help another tenant to the bathroom when she heard someone call for help and it was Tenant #1. She found Tenant #1 between the bed and the door. Tenant #1 was flat on Tenant #1's back and the legs were down. Tenant #1's walker was nowhere near. Tenant #1 was fully clothed and was very confused. Tenant #1 did not know what happened. The nurse was called immediately, the nurse took over and the paramedics arrived. At the last time Tenant #1 was checked Tenant #1 was asleep in bed at 4:00 a.m. Tenant #1 was independent with toileting on third shift. Staff #1 said staff handled the situation appropriately. Staff #1 said there was enough

staff to meet the needs of the tenants and none of the tenants exceeded the level of care.

Staff #2, a registered nurse, worked third shift at the attached nursing facility and responded to the incident. Staff #2 was interviewed. Staff #2 said the staff on duty found Tenant #1 on the floor and notified Staff #2. Staff #2 responded and completed a head to toe assessment. Tenant #1 was not able to move the right leg. Tenant #1 complained of pain in the lower right hip. Upon assessment it was determined Tenant #1 needed to have an x-ray. A pillow was put under Tenant #1's head and Tenant #1 was given a blanket. Staff #2 called in a second nurse to come and help. Tenant #1's spouse and the doctor were notified. Tenant #1 was fully dressed besides shoes. Staff #2 said staff handled the situation appropriately and staff did not move Tenant #1.

The Assisted Living (AL) Coordinator said Staff #1 was completing rounds, helping another tenant and heard Tenant #1 calling for help. Tenant #1 was found on the floor. Staff #1 contacted Staff #2 and Staff #2 did an assessment. Tenant #1 was in pain and was not able to move Tenant #1's leg. The doctor was contacted and Tenant #1 was transferred to a hospital. Tenant #1 was admitted to the hospital for pain control and comfort and surgery was not elected. Tenant #1 was transferred to a skilled nursing facility. The AL Coordinator said there was enough staff to meet the needs of the tenants and none of the tenants exceeded the appropriate level of care.

Review of the pendant history revealed Tenant #1's pendant was not activated on 12-23-12.

The Program's policy regarding incidents/accidents indicated if a tenant was found on the floor or was seen falling, a nurse was to be called and the tenant was not to be moved. The nurse assessed the tenant and determined if first aid was needed or if a doctor needed to be called. If the nurse determined an injury had occurred the nurse notified the doctor and family if the tenant agreed to be seen. The nurse called 911 for an ambulance and copied the face sheet, insurance cards and doctor's orders. The nurse and companion completed an incident report and a Department Head was notified of the transfer. It appeared the Program followed the policy regarding incidents/accidents related to the incident with Tenant #1.

An incident report was completed related to the incident and the incident was reported to the Department.

Review of a tenant file, incident reports, review of the policy regarding incidents/accidents, staff interviews and an interview with the AL Coordinator did not reveal any concerns regarding the incident with Tenant #1.

- Regulatory Insufficiency: None noted.