IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 42124-I

January 28, 2013

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

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

Dear Ms. Cook:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 9 & 10, 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 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
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 #:** 42124-I

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

Date of Complaint/Incident Investigation:

January 9 & 10, 2013

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:	75
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	76
TOTAL census of Assisted Living Program	76

Program History – There were substantiated Regulatory Insufficiencies found during this certification period for Service Plan, Medications, Staffing 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 an attempted suicide. A tenant was found on the floor with wrists slit and a wound to the chest. The tenant did not have a known history of depression or suicide attempts. The tenant was transported to the Emergency Room (ER). The Program also reported the tenant had unaccounted medications prior to the attempted suicide.

- Monitoring Observation: Two tenant files (Tenants #1 and #2) were reviewed. Tenant #1 had attempted suicide.

  Tenant #1, a 63 year old was admitted on 9-4-12 and diagnoses included: Diabetes with Neuropathy, Adjustment Disorder, Colon Perforation and Narcolepsy. Tenant #1 scored a 26/29 on the Mini Mental Status Examination on 11-1-12, which indicated normal to very mild impairment.

  According to Incident Report Forms dated 12-26-12 and 1-6-13, Tenant #1 verbalized concern regarding missing Ritalin pills. Tenant #1 stated Tenant #1 took four Ritalin pills per day for Narcolepsy. The Ritalin was filled on 12-6-12 with 120 pills. On 12-23-12, Tenant #1 noticed the pills were lower than expected. Tenant #1 stated Tenant #1 lost things a lot and dropped things on the floor. Staff searched the room and found 17 pills in various containers. Tenant #1 admitted to keeping pills in multiple containers and did not believe the pills were stolen.

  According to the AL Director, Tenant #1 said Tenant #1 knocked things off into the trash and on the floor. The AL Director suggested Tenant #1 obtain a lock box for the medication after the report on 12-26-12.

After the report on 1-6-13, the AL Director asked if Tenant #1 had gotten a lock box for medication and Tenant #1 said Tenant #1 would look into it. A suggestion was also made that Tenant #1 could have the Program administer the medication.

According to an Incident Report, on 1-8-13 at 6:30 a.m. Tenant #1 was found in the shower on the floor with multiple wounds (bilateral wrist and chest). Tenant #1 stated Tenant #1 had tried to kill himself/herself. The Incident Report indicated 911 was called. Tenant #1's responsible party and the AL Director were also notified.

Nurse's Notes dated 1-8-13 at 6:30 a.m. indicated Staff #1 entered Tenant #1's apartment to respond to the pendant request. Tenant #1 was found lying in the shower on the floor with multiple wounds (bilateral wrist and chest). Tenant #1 was alert and said Tenant #1 had tried to kill himself/herself. Staff #1 summoned staff to Tenant #1's apartment for assistance and called 911. The AL Director was also notified. Nurse's Notes dated 1-8-13 at 6:37 a.m. indicated the medics arrived, took over care and transported Tenant #1 to a hospital. The police department also arrived. Tenant #1's family and doctor were notified. According to Nurse's Notes dated 1-8-13, a nurse at the hospital reported Tenant #1 underwent a procedure to repair a lacerated liver. The nurse from the hospital verbalized Tenant #1 was in stable condition. Nurse's Notes dated 1-10-13 indicated Tenant #1's family was contacted regarding Tenant #1 not being able to return to the Program due to the nature of the circumstance and a discharge letter would be sent. Tenant #1's family verbalized understanding. Nurse's Notes dated 1-10-13 indicated Tenant #1's family would be arranging for movers to clear out Tenant #1's apartment but was unsure of when that would occur. Tenant #1 was transferred to another hospital on 1-9-13.

According to a Nurse Review dated 11-1-12, Tenant #1 had been increasingly weak over the last week. Tenant #1 required assistance with bathing, dressing and at times used the pendant for assistance with transfers. Tenant #1 used a walker for short distances and used a wheelchair for longer distances due to increased weakness. Tenant #1 self propelled the wheelchair inside the Program. Cognitive, health and functional evaluations and the service plan was updated on 11-1-12 with a change in condition. The service plan did not identify any behavioral concerns. Tenant #1 was independent with medication administration; however, staff assisted with daily blood sugar checks. Tenant #1's Health History and Physical indicated Tenant #1 was prescribed Ritalin 20 mg four times daily. Tenant #1 received physical therapy services.

Meal attendance records indicated Tenant #1 consistently attended meals; however, at times did not come out for breakfast. Tenant #1 came out for all meals on 1-7-13, the day before the incident.

Staff #1 was interviewed and had a written statement. Staff #1 was a licensed practical nurse (LPN) and worked first shift. Staff #1 had gotten report, counted narcotics, was going over the morning agenda when Tenant #1's pendant went off. Staff #1 went straight to Tenant #1's apartment. Staff #1 went into the apartment and noticed Tenant #1 was not in bed, she went into the bathroom and Tenant #1 was lying on the floor. She saw blood and asked if Tenant #1 had fallen and Tenant #1 said Tenant #1 had tried to kill himself/herself. Tenant #1 was in the shower, on Tenant #1's back looking up.

Staff #1 said there was blood everywhere and she saw a knife and immediately called other staff for assistance. Staff responded and Staff #1 called 911. She was on the phone with the medics; they wanted to keep her on the line and walked her through things. Staff #2 and other staff put towels on the wounds. The medics arrived and transported Tenant #1. Staff #1 said Tenant #1 did not verbalize to her how long Tenant #1 had been there. She heard Tenant #1 told staff Tenant #1 had been there all night. That was mentioned to the police and medics who said that could not have happened. The AL Director was notified. Staff #1 said Staff #2 and the other staff did a wonderful job. Staff #1 said Tenant #1 did not have any scheduled services overnight or early morning. Tenant #1 did not have any checks overnight. Tenant #1 received assistance with blood sugar checks usually between 7:00 a.m. to 7:30 a.m. Staff #1 said she had not heard of any suicidal ideations with Tenant #1 or any other tenants. Staff #1 said there was nothing unusual in the time prior with Tenant #1 and Tenant #1 went to meals and attended exercises. Staff #1 said it was very unexpected.

Staff #2 was interviewed and had a written statement. Staff #2 was an LPN and worked third shift. Staff #2 was alerted via walkie-talkie that all nursing staff needed to respond to Tenant #1's apartment. Staff #2 got to the apartment and there were two to three staff there. Tenant #1 was observed lying partially in and partially out of the shower. There were lacerations to the wrists and the chest was bleeding. Staff grabbed towels to put on open areas and tourniquets (belts) were applied to both forearms. The medics arrived and took care of everything. There was a knife in the shower approximately the length of a hand. Tenant #1 did not receive any scheduled services and was independent on third shift. Staff #2 said there was nothing unusual with Tenant #1 and there had been no suicidal ideations with Tenant #1 or other tenants.

Staff #3 provided a written statement dated 1-8-13 and indicated at 6:30 a.m., the nurse called for help. When she came into the room Tenant #1 was on the floor in the shower covered in blood. Tenant #1 had a wound to the lower chest and about one inch wide cuts, one on each wrist. The nurse left to call 911 while three other staff and two nurses came in to help apply pressure to the wounds. Staff #3 asked Tenant #1 what happened and Tenant #1 said "I want to die." The medics arrived shortly after. There was a five to six inch kitchen knife in the shower.

Staff #4 provided a written statement dated 1-8-13 and indicated at 6:30 a.m. there was a page for help. When she arrived Tenant #1 was on the bathroom floor, half way out of the shower with both wrists cut and the stomach. Staff #2 came in and covered both wrists with towels and wrapped belts around the wrists to stop the bleeding. Staff #3 and Staff #4 held the wrists until the medics arrived.

Staff #5 provided a written statement indicating Staff #1 and Staff #3 called over the radio for help. When Staff #5 arrived, Tenant #1 was half in the shower and half out. Both wrists were cut deep with a knife as well as the middle chest. Staff #2, #3 and #6 put pressure on Tenant #1's wrists while Staff #5 held pressure on the chest. There was water all over the floor and blood. The knife used was inside the shower.

Staff #6 provided a written statement dated 1-8-13 and indicated Staff #1 paged over the radio she needed assistance immediately.

Staff #3 went to assist and then called over the radio that assistance was needed right now. When Staff #6 got to the room, she saw Tenant #1 lying on the floor with blood and water everywhere and a kitchen knife lying in the shower. Staff #2, #3 and #5 all grabbed towels and began to cover up open wounds on both wrists and abdomen. Staff #6 grabbed belts off the bed and tried to apply them above the cut to help stop bleeding. Staff #3 held a towel to the right wrist and Staff #5 held a towel on the abdomen and Staff #6 after putting the belt on tight held pressure to the left wrist. Staff #6 asked Tenant #1 if Tenant #1 was okay and Tenant #1 said Tenant #1 just wanted to die and had been lying there for eight hours and just pushed the button at 6:00 a.m. Tenant #1 kept saying Tenant #1's neck hurt.

The AL Director was interviewed and said on 1-8-13 at approximately 6:45 a.m. she received a call from Staff #1 who reported she had answered a call from Tenant #1. Staff #1 found Tenant #1 on the shower floor with lacerations on both wrists and a chest wound. The AL Director asked if emergency personnel were there and she was told that Tenant #1 had already left for the ER. The AL Director asked if Tenant #1 was alert and was told that Tenant #1 was alert. Staff #1 said that Tenant #1 told her Tenant #1 tried to kill himself/herself. The AL Director instructed Staff #1 to call Tenant #1's family and to notify Tenant #1's doctor. The AL Director arrived at the Program at approximately 7:05 to 7:10 a.m. She met with Staff #1 and made sure staff was able to continue working. She met a police officer in the hall who stated he had taken photos and to keep staff out of the apartment and keep the door locked until the police department gave clearance to clean the room. Later that afternoon a police officer called and said the room could be cleaned. The AL Director stated Tenant #1 had not made any previous comments regarding suicide. At this time an involuntary discharge notice was being issued.

An incident report was completed and the Department was notified appropriately.

Review of the Program's investigation, incident report, staff interviews and review of Tenant #1's file was completed. Prior to the time of the incident Tenant #1 had not verbalized any suicidal ideations. The Program was in process of issuing an involuntary discharge notice.

- Regulatory Insufficiency: None noted.