IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 42121-I
42341-I

February 19, 2013

Ms. Rhonda Allen, Manager
Parkers Place Retirement Community
707 Highway 57
Parkersburg, IA 50665

RE: Final Complaint/Incident Investigation Report – Parkers Place Retirement Community, Parkersburg, IA

Dear Ms. Allen:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of February 5, 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:

Rhonda Allen, Manager
Parkers Place Retirement Community
707 Highway 57
Parkersburg, IA 50665

Complaint/Incident Intake #: 42121-I
42341-I

Date of Complaint/Incident Investigation:

February 5, 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:	21
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	21
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	5
TOTAL census of Assisted Living Program	26

Program History – The program has not received 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 #42121-I: The Program reported a tenant had fallen in the hallway and did not appear to have any injuries. The tenant later complained of pain and was evaluated at the Emergency Room (ER) and diagnosed with an avulsion fracture of the greater trochanter.

- Monitoring Observation: Three tenant files (Tenants #1, #2 and #3) were reviewed.

  Tenant #1, an 86 year old, was admitted on 5-14-12 and diagnoses included: Legally Blind, Dementia with Behavior Disturbances consisting of delusions and paranoid thoughts, Parkinson's, Degenerative Arthritis and Gastro Esophageal Reflux Disease. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. According to a Service Plan dated 12-26-12, Tenant #1 could use a wheeled walker independently. Staff was to provide stand by assist when ambulating due to a history of falls. Tenant #1 would get up and ambulate without staff and when staff saw Tenant #1 they were to go and walk beside Tenant #1. Tenant #1 had visual checks every 30 minutes. Documentation of visual checks were reviewed from 11-1-12 through 1-3-13 and were completed consistently.

According to an Incident Report, on 1-3-13 at 10:00 a.m. staff heard Tenant #1 yelling in the hallway. Tenant #1 was found lying on the floor. Tenant #1 stated Tenant #1 was sitting on the walker and it slid out from under Tenant #1. Tenant #1 complained of left hip pain, left shoulder pain and head pain. The Nurse was notified and documented no rotation of left leg, legs were same length. Tenant #1 complained of pain. After the pain medication Tenant #1 was able to bear weight on the left leg. A bruise was noted on the left temple. The Nurse noted the Universal Worker (UW) had last seen Tenant #1 at 9:45 a.m. sitting in the television room. Tenant #1 was up by Tenant #1's self while staff was in another room. Tenant #1 requested x-rays.

According to the Nurse's Notes, on 1-3-13 at 10:00 a.m. Tenant #1 had active range of motion (ROM) to all extremities. The UW and the Nurse assisted Tenant #1 up with a gait belt to the walker chair and rolled Tenant #1 to Tenant #1's room and placed Tenant #1 in a recliner. Tenant #1's legs were equal in length, no rotation noted. Tenant #1 complained of left hip pain and an as needed medication was given. According to the Nurse's Notes on 1-3-13 at 11:00 a.m., Tenant #1 was sitting in the recliner and able to lift left leg and complained of left hip pain. Tenant #1 stated Tenant #1 felt a little better but wanted x-rays. On 1-3-11 at 11:15 a.m., a family member was notified and agreed to x-rays. At 11:30 a.m. 911 was called and Tenant #1 was sent to the ER via ambulance at 11:46 a.m. Tenant #1 was alert, oriented to person and complained of left hip pain. According to the Nurse's Notes on 1-3-13 at 4:15 p.m. a call was placed to the ER and it was reported Tenant #1 had a hip fracture and would be admitted to the hospital. According to the Nurse's Notes on 1-7-13 at 4:30 p.m., a call to the hospital reported Tenant #1 had a brace and transferred with two. At 4:31 p.m., a call was received from social services and indicated the family wanted Tenant #1 placed in a nursing home. According to a written statement from the Nurse Clinician, Tenant #1 was discharged from the Program on 1-31-13 which was the date the family removed all the furniture and gave up possession of the apartment.

The Nurse stated Tenant #1 got up and was on the north hall. The UW had seen Tenant #1 10 to 15 minutes earlier. The Nurse and the UW lifted Tenant #1 up. Tenant #1 had some pain and ROM was good. Tenant #1 was given a pain medication. All classic signs of a fracture were fine; there was no shortening or rotation. Tenant #1 was sent to the ER. A family member called and stated Tenant #1 was being admitted to the hospital for a hip fracture but it was just a crack and no surgery would be performed. Tenant #1 would be given a long leg brace. Tenant #1 was transferred to a nursing home.

The Manager said Tenant #1 fell in the north hallway where Tenant #1 was walking with a walker. Tenant #1 stopped to sit on the walker chair and fell as Tenant #1 went to sit down. The UW said she had just checked on Tenant #1 before the incident. The UW heard Tenant #1 in the hallway. The Manager was on her way to the dementia unit and she went with the UW to the north hall. Tenant #1 was found on the floor with the walker. The Nurse arrived and assisted the UW in getting Tenant #1 up. Eventually the ambulance was called. The Manager said Tenant #1 used the walker.

The Manager and the Nurse stated the Incident policy was followed, the situation was handled appropriately and there was enough staff to keep the tenants safe.

The Program completed an incident report and reported the incident to the Department.

Review of tenant files, staff interviews, review of incident reports and review of policies did not reveal any issues related to the incident with Tenant #1.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #42341-I: The Program reported a tenant was found lying on the bathroom floor and transported to the ER. The tenant was diagnosed with a fractured clavicle.

- Monitoring Observation: Three tenant files (Tenants #1, #2 and #3) were reviewed.

Tenant #2, an 84 year old was admitted on 4-7-11 and diagnoses included: History of Bronchitis, Nocturnal Incontinence, Dementia, Cataracts, History of Falls, History of Hip Fracture with Surgical Repair, History of Dizzy Spells, History of Urinary Tract Infection, Constipation, Hypertension and Diarrhea. Tenant #2 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. Tenant #2 was out of the Program at the time of the investigation.

The service plan updated on 1-3-13 indicated Tenant #2 wore slipper socks with grips on the bottom at night due to falls. The service plan also indicated Tenant #2 was visually checked eight times per shift and Tenant #2 had a history of falls and dizzy spells. Staff reminded Tenant #2 to get up slowly as needed. The service plan reflected Tenant #2 was independent with an assistive device (walker) and used a wheelchair for longer distances as needed. At times Tenant #2 used a walker and staff reminded to use it if Tenant #2 was up without it. Staff provided stand by assistance to and from activities and meals in the dining room. The service plan also reflected Tenant #2 liked cough drops and cups of water around the apartment. Documentation of visual checks was consistently documented as completed.

According to an Incident Report dated 1-12-13 at 5:45 a.m. staff checked on Tenant #2 and 10 minutes later heard a thud. Staff went to Tenant #2's apartment and found Tenant #2 lying on Tenant #2's side in the shower. Staff called another UW to come and help. The Nurse was called and it was decided to call an ambulance. Tenant #2 was found half in the shower and legs out on the bathroom floor. Tenant #2 was lying on the right shoulder with arm under Tenant #2. There was an open area on the right forehead. Tenant #2 was wearing the grip socks and there was a cup on the floor with water on the floor. Tenant #2 was sent to the ER and family was notified.

According to Nurse's Notes dated 1-14-13, on 1-12-13 Tenant #2 was found on the bathroom floor. Tenant #2 was wearing grip socks and the walker was in the bedroom. The UW had last seen Tenant #2 10 minutes prior. Tenant #2 was found lying on the right side with the right arm behind Tenant #2. Tenant #2 had a small cut on the right temple. Tenant #2 would not allow pressure to be applied. Tenant #2 was assisted to a sitting position. Per the UW Tenant #2 used all extremities. An

ambulance was called and Tenant #2 was taken to the ER. Tenant #2's family was informed of the incident. Tenant #2 had a fractured clavicle and was taken to a nursing home.

According to an Incident Report dated 12-20-12 at 3:40 p.m., staff was finishing up visual checks and heard Tenant #2. Staff went to Tenant #2's apartment and found Tenant #2 on Tenant #2's knees next to a half-eaten orange. Tenant #2 did not have any complaints of pain and was assisted from the floor. According to an Incident Report dated 11-8-12 at 4:43 p.m., Tenant #2 was walking to the dining room table in an apartment and lost Tenant #2's balance. Tenant #2 did not complain of pain and was assisted to Tenant #2's feet.

Staff #2 was working at the time of the incident and was interviewed. Staff #2 had just checked on Tenant #2 and about 10 to 15 minutes later heard a thud. Staff #2 found Tenant #2 half in the shower and half on the bathroom room floor. Tenant #2 did not activate the pendant and was not wearing it. Tenant #2's walker was by the bed. Tenant #2 complained the arm was sore and was burning hot. There was a bump on the right side temple area and it was bleeding. Staff #2 called another staff for assistance and also called the Nurse. An ambulance was called, they arrived and took over. Tenant #2 was in night clothes and was wearing slipper socks. Tenant #2 had a tendency to forget to use the walker. Tenant #2 had one hour checks completed. Staff #2 said the situation was handled appropriately and there was enough staff to meet the needs of the tenants.

The Nurse stated Tenant #2 was up to the bathroom by Tenant #2's self and was found on the floor. Tenant #2 was wearing slipper socks with grips. Tenant #2 was sent to the ER and was diagnosed with a fracture of the clavicle. Tenant #2 was sent to a nursing home the same day with a brace. The Nurse stated Tenant #2 did not routinely use a walker; staff would assist Tenant #2. Tenant #2 was on hourly checks.

The Manager said Tenant #2 used a walker quite a bit. She knew Tenant #2 fell in the bathroom and complained of pain. An ambulance was called right away and Tenant #2 went to the hospital and then to a rehabilitation center the same day. The Manager said Tenant #2 was still at the rehabilitation center and hoped Tenant #2 would return to the Program.

The Manager and the Nurse stated the Incident policy was followed, the situation was handled appropriately and there was enough staff to keep the tenants safe.

The Program completed an incident report and reported the incident to the Department.

Review of tenant files, staff interviews, review of incident reports and review of policies did not reveal any issues related to the incident with Tenant #2.

- Regulatory Insufficiency: None noted.