IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
44928-I
44826-I

September 26, 2013

Ms. Diana Niemeier, Executive Director
Village Ridge
365 Marion Boulevard
Marion, IA 52302

RE: Final Complaint/Incident Investigation Report, Village Ridge, Marion, Iowa

Dear Ms. Niemeier:

Enclosed is the **Final Complaint/Incident Investigation Report** 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to 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 #:** 44928-I 44826-I

Diana Niemeier, Executive Director/Director of Health Services
Village Ridge
365 Marion Boulevard
Marion, IA 52302

Date of Complaint/Incident Investigation:

August 28 & 29, 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:	38
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	42

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	18
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	60

Program History – During the March 14, 2013 Recertification on-site the program received a regulatory insufficiencies in the area of Policies and Procedures.

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

A. Other

Complaint/Incident Allegation #44928-I: The Program reported a tenant fell and did not sustain any injuries. The tenant fell again later that night and sustained a fracture.

- Monitoring Observation: Tenant #1, a 93 year old, was admitted on 3-8-13 and diagnoses included: Memory Loss, Urinary Incontinence, Right Knee Pain and Glaucoma. Tenant #1 scored a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the memory care unit. The service plan updated 6-17-13 indicated Tenant #1 was independent in memory care with mobility and transfers and supervised when out. When out, staff observed Tenant #1's location. Tenant #1 ambulated without any devices. According to a Fall Assessment: Predisposition for Falls document, Tenant #1 was not identified as a risk for falls.

  According to an Incident/Accident Report, on 8-4-13 at 3:50 p.m. Tenant #1 was found seated on bathroom floor on bottom with both legs straight out in front of Tenant #1. Full range of motion (ROM) and no bruising, pain or discomfort noted. Tenant #1 stated, "I fell and I sat." Tenant #1 was assisted up and into a seated position on the toilet and vitals were taken.

According to an Incident/Accident Report, on 8-4-13 at 10:10 p.m. Tenant #1 was found during shift change rounds on the bathroom floor in a seated position. Tenant #1's right leg was turned outward at an odd angle and Tenant #1 complained of hip and right thigh pain. The right hip/thigh area was painful and no ROM. Tenant #1 stated Tenant #1's hip hurt. An ambulance was called and Tenant #1 was kept immobile. Tenant #1 was admitted to the hospital with a diagnosis of right hip fracture.

According to Nurse's Notes dated 8-4-13, Tenant #1 was found seated on floor of bathroom on bottom with legs straight out front. Tenant #1 stated, "I fell and sat down here." Tenant #1 had no complaints of pain and full ROM. Tenant #1 had no bruising or visible injury. Blood pressure 120/60, pulse 70 and respirations 16. temperature was 97.6 degrees. Tenant #1 was assisted by staff to a seated position on toilet. The on call nurse was notified, family was notified and the doctor was faxed.

According to Nurse's Notes dated 8-4-13 at 10:35 p.m. Tenant #1 was found on bathroom floor at shift change in a seated position. At 10:10 p.m. right leg was turned outward at an odd angle and Tenant #1 complained of hip pain and right leg pain. Tenant #1 was sent to the emergency room via ambulance for evaluation. Tenant #1's family was notified and the on call nurse was notified. Blood pressure was 120/70, pulse 80 and respirations 18. Tenant #1 was admitted to the hospital with a hip fracture.

Staff #1 stated a little after 10:00 p.m. on the date of the incident she was on her way to memory care to count and do report. Staff #2 was paged to go to Tenant #1's apartment by Staff #3. Since Staff #1 was headed that way she followed Staff #2. Staff had been doing rounds and found Tenant #1. Staff #1 and #2 entered the apartment. Staff #3 and #4 were already there. Tenant #1 was sitting on the bathroom floor in nightwear without any shoes or socks. Staff said they came into the room on rounds and found Tenant #1 in that position. Staff #3 had been in the room one hour prior. Tenant #1's right foot was rotated. Staff #1 told the others not to move Tenant #1 and she left to call 911. Staff #1 called Tenant #1's family to report the fall and said the hip might be fractured. Tenant #1 said the right hip area hurt and pointed to the area. Staff #1 noticed Tenant #1 had a bunch of toilet paper, still on the roll, was behind Tenant #1 piled on the floor beside Tenant #1. Staff #1 said Staff #2 called the on call nurse, LPN #2.

According to Staff #2, in early August at the end of the shift, staff did rounds to each tenants' room. Staff found Tenant #1 in the bathroom on the floor in a seated position. Staff #2 entered Tenant #1's apartment with Staff #1. Tenant #1 was facing the shower with back against the wall. Left leg was bent and the right leg was out front and turned awkwardly. Staff #2 decided not to move Tenant #1 who expressed some pain. Tenant #1 had had previous falls, but it was more serious this time. Tenant #1 was kept stable and staff stayed in the room with Tenant #1. There was nothing in the bathroom that could have caused the fall. Tenant #1 was barefoot. Tenant #1's slippers were next to the bed. Staff #2 stated she called LPN #2, 911 and started the incident report. Staff #2 stated Tenant #1 had fallen earlier on the shift. Staff #2 called LPN #2, Tenant #1's family and completed an incident report. Staff #2 and LPN #2 talked about getting grippy socks, to check Tenant #1 every hour and to leave the bedroom door open since Tenant #1 had a habit of locking the apartment door.

Staff #3 stated on August 4th or 5th she got Tenant #1 ready for bed at 8:00 p.m. and then checked at 9:00 p.m. and Tenant #1 was asleep. Between 10:00 and 10:15 p.m. Tenant #1 was found on the floor in the bathroom by the shower. Staff #3 paged the med passers to help with Tenant #1 and they called 911. Staff #3 took the vitals and they were normal. Tenant #1 was sitting with back to the wall with one leg straight and one bent at the knee. Tenant #1 was wearing nightwear and was barefoot. Lots of toilet paper from the roll was all over the floor. Staffs #2 and #3 stayed in the room with Tenant #1 until the ambulance arrived. Tenant #1 complained of lower back and hip pain. Staff #3 stated Tenant #1 fell earlier that day. Tenant #1 had gotten off the toilet and the Tenant's feet went out.

A written statement from Staff #4 indicated while doing rounds with second shift a few minutes after 10:00 p.m., he found Tenant #1 on the bathroom floor sitting up. Tenant #1 said Tenant #1 lost balance when going back to bed after using the bathroom. Tenant #1 did not have any shoes or socks on and there was no urine on the floor. Tenant #1 didn't use any walking device. Tenant #1 complained of pain in the right leg.

Staff #5 stated when Tenant #1 lived in the general population Physical Therapy took away the walker and cane as it was too dangerous for Tenant #1 to use. Tenant #1 would pick up the devices and carry them instead of using them correctly. On the night shift Tenant #1 was not steady when first getting up to go to the bathroom but would walk normally on the way back to bed. Tenant #1 was awakened every two hours to go to the bathroom. Tenant #1 walked normaly in memory care when Staff #5 saw Tenant #1.

LPN #2 stated Staff #2 called her between 5:00 p.m. and 6:00 p.m. regarding Tenant #1's fall. Staff #2 said Tenant #1 was okay, had no complaints of pain and could move all extremities. LPN #2 advised staff to keep observing Tenant #1. Staff #2 called around 10:00 p.m. or 10:30 p.m. and reported while doing rounds Tenant #1 had fallen and the leg did not look right. She instructed staff to call 911, wait for the emergency personnel to move Tenant #1 and notify Tenant #1's family. LPN #2 stated Tenant #1 had falls, about one or two a month since moving to the Program. This was the first fall with an injury. Tenant #1 would say Tenant #1 lost balance and would sit self down. Tenant #1 dressed and undressed independently and that was when Tenant #1 would fall. LPN #2 stated staff followed the process for notifying the nurse on call.

The Assistant Director of Health Services said she was not on call the night of Tenant #1's incident but she called the Program around midnight and directed staff to call the hospital to find out Tenant #1's diagnosis. Tenant #1 had a fractured hip. The next day the she started an investigation and obtained interviews from staff. She said staff responded appropriately and notified the nurse per expectations. The staff was a good team and communicated well with each other. Staff knew to make hourly rounds and checked on Tenant #1 frequently.

The Executive Director/Director of Health Services stated LPN #2 was on call at the time of Tenant #1's incident. The Assistant Director of Health Services called her the morning after and told her Tenant #1 was in the hospital with a hip fracture. She came in and talked to Staff #1 and #4 and told them to write statements. She started an internal investigation and reported the incident to the Department. Tenant #1 had on nightwear and was barefooted with toilet paper to Tenant #1's side. Tenant #1 was facing the shower, the hip was rotated out. Staff called LPN #2 who gave the directive to not move Tenant #1, call the ambulance and stay with Tenant #1. Staff called 911, Tenant #1's family and the hospital. Tenant #1 was discovered during rounds. Staff #3 said she assisted Tenant #1 into bed between 8:15 p.m. and 8:30 p.m. and went back around 9:15 or 9:30 p.m. Tenant #1 was asleep at that time. She said staff handled the situation very competently.

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

Review of the Program's investigation, incident reports, staff interviews and review of Tenant #1's file did not reveal any issues related to the incident with Tenant #1.

- Regulatory Insufficiency: None noted.

B. Nurse Review

Complaint/Incident Allegation #44826-I: The Program reported a tenant called for assistance, was found outside the tenant's bathroom and the front of the tenant's head was bleeding. The nurse on duty administered first aid and the tenant was transported to a hospital. The tenant had an extensive bilateral acute subdural hematoma.

Monitoring Observation: Tenant #2, an 84 year old, was admitted on 7-16-13 and diagnoses included: History of Syncope and Collapse, Type II Diabetes Mellitus, Hypertension, Hyperlipidemia, History of Transient Ischemic Attack, Restless Leg Syndrome, Chronic Lower Extremity Edema, History of Macular Degeneration, Urinary Incontinence, Renal Insufficiency, History of Insomnia and Scalp Abrasion. Tenant #2 was staged at a 3.2 on the GDS, which indicated mild, minimal impairment. Nurse's Notes dated 7-16-13 indicated Tenant #2 had just moved to Iowa a week ago, then moved to Independent Living and the next day was found on the apartment floor and was sent to the Emergency Room (ER). Tenant #2 was discharged from a hospital and was admitted to the Program on 7-16-13. Tenant #2's Emergency Medical Request Form indicated Tenant #2 was a Do Not Resituate (DNR) and Do Not Intubate (DNI).

According to the service plan, Tenant #2 was independent with personal and health related cares. According to the service plan, Tenant #2 had a recent move to the Program and staff reminded Tenant #2 of meals, activities and location for two weeks. Staff also knocked on the door in the morning to inform Tenant #2 of breakfast for two weeks. Tenant #2 administered medications independently and oxygen (which was noted as pending on the service plan). According to a medication list Tenant #2 took Aspirin 81 milligrams enteric coated tablet, by mouth daily. According to a Fall Assessment: Predisposition for Falls document, Tenant #2 was identified as a risk for falls. The document indicated Tenant #2 worked with therapy at the hospital and to continue when discharged. The service plan reflected a therapy screen.

According to Nurse's Notes, on 7-19-13 at 5:25 a.m. Tenant #2 was seen exiting the elevator dressed in a robe and barefoot looking for a cup of coffee. Staff got Tenant #2 a cup of coffee and Tenant #2 sat by the fireplace, drank the coffee and returned to the apartment after verbal prompting and orientation to time. Nurse's Notes dated 7-20-13 indicated at 6:00 a.m. Tenant #2 was by Tenant #2's door hollering to get the fire, police and ambulance. When asked why, Tenant #2 stated Tenant #2 fell off a two story ladder. Staff checked Tenant #2 over and saw no new bruises or red marks. Tenant #2 was also looking for Tenant #2's spouse and wanted to call Tenant #2's family. Tenant #2 was redirected to get ready for breakfast. Tenant #2 came down and ate a good breakfast and went back to Tenant #2's apartment. Tenant #2's family was called at Tenant #2's request. According to Nurse's Notes dated 7-20-13 at 9:30 p.m. Tenant #2 came off the elevator in a robe and barefoot without a walker and said Tenant #2 missed breakfast. Tenant #2 was reoriented to time and place and escorted back to the apartment. Nurse's Notes dated 7-20-13 (at either 10:30 p.m. or 11:30 p.m.) indicated Tenant #2's family member phoned the Program and said Tenant #2 had called the family member and said Tenant #2 fell. Staff went to Tenant #2's apartment and Tenant #2 was standing by Tenant #2's desk. Staff asked Tenant #2 if Tenant #2 had fallen and Tenant #2 denied falling and said Tenant #2 had called the family member yesterday. Tenant #2 was checked at 2:00 a.m. and 4:00 a.m. and was asleep. According to Nurse's Notes dated 7-21-13 at 1:30 p.m., Tenant #2 was eating breakfast and staff saw a red mark on Tenant #2's forehead. Tenant #2 was asked what happened and Tenant #2 stated Tenant #2 fell out of bed. When Tenant #2 returned to the apartment Tenant #2 was checked over and vitals were taken. A bruise was found on the back and top of shoulder along with forehead, there were various old bruising on buttocks and arms. Tenant #2 also fell asleep while staff took vitals and talked to Tenant #2. Tenant #2 was also falling asleep while talking to self. The family member was called and felt confident not taking Tenant #2 to be seen as Tenant #2 would be going to the doctor on 7-22-13.

According to an Incident/Accident Report dated 7-21-13, Tenant #2 was very confused and could not answer questions appropriately. The report indicated the incident was not witnessed by anyone and occurred in Tenant #2's apartment. Tenant #2's status prior to the incident was indicated as confused. The report indicated there was no injury; however, the report indicated there was an abrasion on Tenant #2's forehead, the top right shoulder was open and red and there was bruising on the lower left side (new discoloration). Vitals were obtained and were as follows: blood pressure 120/60, temperature 97.8, pulse 96 and respirations 24. Tenant #2 was checked on frequently and Tenant #2's family member felt Tenant #2 was okay since the family member had just talked to Tenant #2.

According to a Fall Monitoring Plan, the date of the fall was 7-21-13 and time was indicated as a.m. The nurse was notified at 9:30 a.m. The form indicated to begin monitoring immediately after a fall and to check tenant every shift for 36 hours after the fall for the signs of serious injury. The items included: loss or change of consciousness, drowsiness, difficulty walking, headache or pain that did not get better within four hours, stiff neck, confusion, restlessness, personality change, blurred or double vision, slowed or slurred speech/difficulty speaking, dizziness, poor coordination, dropping things, feeling faint, staggering, weakness, tingling, numbness, bleeding or drainage from ears and nose, nausea or vomiting, swelling, bruising, pain at injured site, seizure or convulsion and if pupils were not equal in size. The form also indicated to report to the RN if systolic blood pressure was greater than 160 and if diastolic blood pressure was greater than 90. It also indicated to report to the RN if temperature was greater than 100 or if respirations were labored. On first and second shift no symptoms were noted with the exception of swelling, bruising, pain at injured site.

According to a fax to the doctor on 7-21-13, Tenant #2 was very confused and oriented to self only. Tenant #2 had hallucinations at various times and had fallen on 7-20-13 and 7-21-13. Bruising was found from 7-20-13 on lower left rib cage and on 7-21-13 found an abrasion red in color on right side of forehead and top of right shoulder had open red area the size of a nickel. Tenant #2 could not tell staff when or how Tenant #2 fell. On 7-20-13 Tenant #2 thought Tenant #2 fell off a ladder two stories and wanted fire, police and ambulance. Tenant #2 looked for spouse that had passed away and would fall asleep while talking to person at times.

Staff #1 was interviewed. She said Tenant #2's family member called and the family member was not sure when it was but Tenant #2 called, left a message and said Tenant #2 had fallen. Staff #1 went to Tenant #2's apartment and Tenant #2 denied falling and there was nothing out of place in the apartment. Tenant #2 seemed alert and oriented. No injuries were observed. At regular shift checks Staff #1 slept the rest of the night.

Staff #5 was interviewed. She said Tenant #2 wanted to call police, ambulance as Tenant #2 reported falling off a two story ladder. There were no visible marks on Tenant #2. Tenant #2's family member was called and came in. The family member reported Tenant #2 had hallucinations and the family member did not want Tenant #2 sent out. Staff #5 kept an eye on Tenant #2 and there were no complaints of pain and no injuries. The next shift was told to keep an eye on Tenant #2. The next morning at breakfast Tenant #2 had a band of polka dots, described as not even a rug burn mid forehead into the scalp. Tenant #2 was checked over and had a bright blue bruise on the rib area and an area on the shoulder. Tenant #2's pupils were checked. Staff #5 called Tenant #2's family member. Vitals were obtained and Tenant #2 kept falling asleep. The family member said Tenant #2 fell asleep when talking to Tenant #2, was confident Tenant #2 was fine and Tenant #2 had an appointment the next morning. Staff #5 sent a fax to the doctor.

Nurse's Notes dated 7-21-13 at 3:00 p.m. indicated Tenant #2 was in the dining room and was reoriented to the time of day and that supper was at 4:30 p.m. Tenant #2 said Tenant #2 was so confused, got up and began pushing dining room chair instead of walker. Tenant #2 was given walker and was redirected to an activity and played Bingo with peers. On 7-21-13 at 6:40 p.m. Tenant #2 paged staff and staff called a nurse. Tenant #2 was observed kneeling outside the bathroom without pants, socks, shoes or walker. Tenant #2's head was bleeding profusely and the nurse applied pressure. Tenant #2 was unable to describe how Tenant #2 hit Tenant #2's head. Tenant #2 had complaints of headache and when asked where Tenant #2 was by Emergency Medical Technicians (EMTs) Tenant #2 stated Tenant #2 was in the hospital. Tenant #2 was sent to a hospital by ambulance. At 10:00 p.m. the ER nurse said Tenant #2 had a very severe head injury, the outcome was very poor and Tenant #2 was going to Hospice care.

According to an Incident/Accident Report, on 7-21-13 at 6:40 p.m. Tenant #2 paged and staff observed Tenant #2 kneeling on the floor without shoes, socks or pants on and without Tenant #2's walker. The front of Tenant #2's head was bleeding profusely. The incident was not witnessed by anyone and occurred in Tenant #2's apartment. Tenant #2's status prior to the incident was noted as confused. Tenant #2 was alert and oriented to self only. There was an injury, which was noted as a front head injury. Tenant #2's oxygen saturation was 95% at room air. Tenant #2 was transported to the hospital for evaluation and treatment.

According to a fax to the doctor dated 7-21-13, Tenant #2 paged and was observed kneeling on the floor outside the bathroom with no pants, shoes or socks and Tenant #2's head (front of head) was bleeding profusely. Light pressure was applied to head with a large towel and 911 was called. An ambulance took Tenant #2 to a hospital. Tenant #2 was alert and oriented to self and complained of headache.

Staff #6 provided a written statement regarding the incident with Tenant #2 and was interviewed. She indicated a call came in at 6:38 p.m. and then Tenant #2 called again about two minutes later. She was about two doors down so she hurried a little bit faster. She came into the apartment and Tenant #2 was on Tenant #2's knees right outside the bathroom door with nothing on but an undershirt. Tenant #2 had blood coming out of the right side of the head. She called LPN #1 on the walkie talkie to come up to the apartment immediately. She told Tenant #2 not to move as Tenant #2 was trying to get up. LPN #1 came into the apartment and told someone to call 911. LPN #1 got a towel and held it on Tenant #2's head until the EMTs arrived. It took between three to five minutes for them to get there. Tenant #2 was conscious but could not tell staff exactly what happened. The EMTs got there and put Tenant #2 on the stretcher and wrapped Tenant #2's head as it was still bleeding. Tenant #2 remembered Tenant #2's birthday but could not remember what year it was and thought Tenant #2 was in the hospital. Staff #6 said Tenant #2 had come down for a meal and then called for assistance approximately one hour after the supper meal. She said it was only the second day she had worked with Tenant #2. Tenant #2 had been confused since Tenant #2 had been there. Tenant #2 had fallen at the Independent Living and had fallen two to three times including the fall which Staff #6 responded.

LPN #1 provided a written statement regarding the incident with Tenant #2 and was interviewed. On 7-21-13 at 6:40 p.m. she was paged to Tenant #2's apartment and observed Tenant #2 outside the bathroom with side wall to Tenant #2's left side glasses with lens out and a belt lying beside the wall. Tenant #2 was kneeling down on all fours and the walker was in the corner of the apartment. Tenant #2 was not wearing shoes, socks or pants and was bleeding profusely from the front of the head. Staff was paged to call 911 and she went to the bathroom and grabbed a large bath towel and put light pressure and helped support Tenant #2's head. Tenant #2 was alert and oriented to self. When asked what Tenant #2 was doing Tenant #2 said Tenant #2 was looking for something in the hamper. Tenant #2 asked her to call a family member. Reassurance was given to Tenant #2 and Tenant #2 was told family would be notified as soon as Tenant #2 was safe in the ambulance. Tenant #2 asked about information on a cork board and there was no cork board observed. Tenant #2 was reassured Tenant #2's insurance information and medication list would be sent to the hospital. Tenant #2 was pleasant and conversed. At approximately 6:43 p.m. EMTs arrived and began working on Tenant #2. Profile and code status along with shoes, pants and a protective undergarment were sent with Tenant #2 to the hospital. The on-call nurse was notified and a message was left. Tenant #2 was seen at supper (before the incident) eating and talking with a peer. Tenant #2 had a light pink abrasion to forehead as Tenant #2 had fallen earlier that day. Staff kept an eye on Tenant #2 and there was nothing unusual with Tenant #2. Tenant #2 was oriented to self and not so much to time or place.

LPN #2 was on-call and said Staff #5 had called in the morning and said Tenant #2 said Tenant #2 had fallen from off a ladder from a two story building. Tenant #2 was new to the Program. Staff #5 did not find any visible marks on Tenant #2 and LPN #2 told Staff #5 to observe Tenant #2. The next day Staff #5 saw some bruising that was not there before. She told Staff #5 to call the family and to continue to observe. She said there was nothing communicated to her that indicated Tenant #2 needed to be sent out and she would have come into the Program if she felt she needed to be there. Closer to 9:00 p.m. Tenant #2 had fallen, LPN #1 was working and provided first aid, 911 was called and Tenant #2 was taken out by ambulance. She said staff followed the policy regarding falls.

According to a Verification of Investigation Form, on 7-21-13 at approximately 6:40 p.m. Tenant #2 was found in the apartment on the floor and 911 was called. It was a non-witnessed fall, staff was called to the apartment by pendant. Tenant #2's doctor was notified, family was contacted and a self-report to the Department was made. The findings indicated Tenant #2 had no ADLs provided by staff. Tenant #2 was independent with ambulation and used a walker. Staff responded and called 911. The family, on-call nurse were notified and the on-call nurse notified the Executive Director.

According to a Major Injury Determination Form, the physician, designee of the physician or physician extender determined Tenant #2 sustained a major injury.

A report regarding Tenant #2's pendant records was reviewed. Records indicated Tenant #2's pendant was activated on 7-21-13 at 6:36:19 p.m. and was acknowledged on 7-21-13 at 6:36:53 p.m. (34 seconds). It was activated again on 7-21-13 at 6:37:58 p.m. and was acknowledged at 6:38:05 p.m. (7 seconds).

According to Tenant #2's hospital records, there were extensive bilateral acute subdural hematomas, left greater than the right. Senescent parenchymal changes and right parietal scalp hematomas without underlying fracture. Tenant #2 had DNR/DNI advanced directives and the family member reinforced no life sustaining interventions. An offer to transfer Tenant #2 to another hospital for neurosurgical consultation was declined and family preferred to make Tenant #2 comfortable. Hospice was consulted and Tenant #2 would be admitted to Hospice service.

The Certificate of Death indicated the date of death was 7-25-13 and the immediate cause of death was as a subdural hematoma and accidental fall. The approximate interval between onset and death was indicated as four days. An autopsy was not performed and the manner of death was indicated as an accident.

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

A nurse review was not completed as needed when an observed significant change in condition occurred related to the confusion and reported fall(s) prior to the fall on 7-21-13 at 6:40 p.m. A nurse review was not completed as needed.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant received personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))