IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 46097-I

December 16, 2013

Ms. Amanda Buchholz, Director
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

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

Dear Ms. Buchholz:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 4, 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:

Amanda Buchholz, Director of Memory Care
Senior Star at Elmore Place ALPD
4504 Elmore Avenue
Davenport, IA 52807

Complaint/Incident Intake #: 46097-I

Date of Complaint/Incident Investigation:

December 4, 2013

Monitor(s):

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	27
Total Population of Program at time of on-site	27
TOTAL census of Assisted Living Program	27

Program History – The program received Regulatory Insufficiencies in the areas of Dementia Specific Education, Service Plan, Evaluation, Criteria for Retention and Admission, Medications, Food Service, Tenant Rights, Policy and Procedure, Staffing and Non Compliance with Plan of Correction 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 Tenant #1 tripped and got foot stuck in a dog bowl. Tenant #1 fell and suffered a fracture.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1, an 89 year old, was admitted on 5-2-13 and diagnoses included: Hypertension, Dementia, Hypothyroid, History of Urinary Tract Infections, History of Kidney Injury, Elevated Liver Enzymes noted for Rhabdomyolysis and Hyponatremia. Tenant #1 scored a five on the Global Deterioration Scale which indicated moderately severe cognitive decline. According to a service plan dated 5-14-13, Tenant #1 was independent with mobility and transfers with the use of an assistive device (cane or walker) and transferred independently. According to an Incident Report Form dated 11-4-13, Tenant #1 was getting up from being weighed, stood up to get walker and accidently stepped in dog's water bowl. Foot got stuck and Tenant #1 fell forward hitting front of head on weight chair. Vital signs were taken: Temperature 98.6, Blood Pressure 205/99, Pulse 80 and Respirations 18. Left shoulder appeared to be injured, couldn't move. Tenant #1's family and physician were notified. According to the Nurse's Notes dated 11-4-13 at 9:00 a.m., Tenant #1 fell and family transported to Emergency Room (ER) to evaluate shoulder pain and physician informed. According to Nurse's Notes dated 11-4-13 at 3:00 p.m. Tenant #1 returned from the ER accompanied by family.

Reported fracture to upper left arm below shoulder. Order received for Hydrocodone/APAP 5mg/325mg one tab every four hours as needed for pain and discomfort. A follow-up appointment with the orthopedic physician was scheduled for 11-5-13 at 8:00 a.m. On 11-5-13 at 10:00 a.m. Tenant #1 returned from the orthopedic appointment with new orders: DC Lortab and give Tramadol 50 mg orally, one tab every six hours as needed; ambulate with assistance only for next four to six weeks and a new brace was applied. On 11-6-13 at 9:30 a.m. Tenant #1 was sitting at dining room table with immobilizer on left arm. Was in good spirits and voiced no complaints of pain. An X-Ray report of the left shoulder indicated a left proximal humeral fracture involving the surgical neck with avulsed fracture fragment. No significant distraction, angulation or displacement.

Staff #1 stated it was a normal day and she was doing the monthly tenant weights. She weighed Tenant #1 in the chair scales and when Tenant #1 went to stand up, Tenant #1 was a little unsteady and Tenant #1's foot got stuck in a dog bowl. Another tenant was close by sitting on a walker waiting to be weighed. Tenant #1 took about two steps before stepping in the dog bowl. Tenant #1 was swaying and fell forward towards the left, looked like a dive like someone diving into a swimming pool. Tenant #1 landed on stomach and left side. Tenant #1 put out arms to break the fall. Staff #1 immediately asked if Tenant #1 hurt. Tenant #1 described shoulder pain. Staff #1 called for help and several staff came, the nurse was right there. The dog dish had two bowls in a metal stand next to a dog bed. Staff #1 stated the dog bowl wasn't in the way at all. She felt the fall had more to do with Tenant #1's unsteadiness and another tenant being in the way. Tenant #1's walker was to the right and a rail on the wall that Tenant #1 grabbed first as Tenant #1 stood up.

According to a written statement by Staff #1 dated 11-5-13, after Staff #1 obtained Tenant #1's vitals, Tenant #1 stood up from the weight chair. Another tenant was somewhat too close, not giving Tenant #1 a lot of room. Tenant #1became unsteady after standing, lost balance and grabbed onto the hand rail and then stumbled a bit more before stepping into the dog bowl.

Staff #2 stated she was in the dining room when Tenant #1 attempted to go to the scales. Tenant #1's walker bumped something as Tenant #1 was walking with the walker and was unsteady. Tenant #1's foot ended up in a dog bowl and Tenant #1 fell, was leaning on left when fell but ended up on other side and right forehead hit a bar on the bottom of the scale. Staff #2 stated everyone responded. The nurse assessed Tenant #1 who was sent to the ER immediately.

Staff #3 stated she was passing medications around 8:30 a.m. and heard a scream and ran to where Tenant #1 was laying. She asked Tenant #1 if Tenant #1 hurt anywhere and Tenant #1 responded no. She took vital signs and slowly assisted Tenant #1 up and assisted into a wheelchair. Five minutes later Tenant #1 stated arm hurt and ten minutes later said the arm was going numb. Staff #3 called Tenant #1's family who stated family would come and take Tenant #1 to the ER. Staff #3 stated Tenant #1 lay on left arm, on left side with legs straight out wearing shoes.

She did not see anything in the way on the floor. Staff #3 stated she didn't notice a walker or a dog dish but they were probably moved by the time she arrived.

The Director of Memory Care stated she was out of the office and received an email from the front desk asking her to call the office. She called at 10:18 a.m. on 11-4-13 and was told Tenant #1 had fallen, family was notified and Tenant #1 was sent out. A decision was made to report the incident to the Department. She contacted the AL Director and asked him to obtain the X-ray results, complete an investigation and report to the Department. Tenant #1 had been independent with the use of a walker.

The Director of AL stated the Director of Memory Care called him and stated there had been a fall and he needed to check into what happened. The next day he called the hospital to obtain the X-ray reports. The report was sent over and it was noted there was a fracture so he completed the online report to the Department.

Staff #2, #3 and the Director of Memory Care stated there was enough staff to meet the needs of the tenants.

According to a Staffing policy, the Program would provide adequate staffing 24 hours per day to meet scheduled and unscheduled or unpredicted needs in a matter that promoted maximum dignity and independence and provided supervision, safety and security. Sufficient trained staff would be provided at all times fully meeting the tenant's identified needs.

An incident report was completed and the Department was notified.

Review of Tenant #1's file, policy review and interviews with staff, the Director of Memory Care and the Director of AL did not identify any areas of concern.

- Regulatory Insufficiency: None noted.