IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
47194-C

April 3, 2014

Ms. Tina Perry, Administrator
Irving Point
910 7th Street SE
Cedar Rapids, IA 52401

RE: Final Complaint/Incident Investigation Report, Irving Point, Cedar Rapids, Iowa

Dear Ms. Perry:

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, following an investigation by DIA on **March 25, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Tenant Documents.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference;** however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

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 #:** 47194-C

Tina Perry, Administrator
Irving Point
910 7th Street SE
Cedar Rapids, IA 52401

Date of Complaint/Incident Investigation:

March 25, 2014

Monitor(s):

Stephanie Cummins, MA
Wendy Kuhse, RN BS

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:	53
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	53
TOTAL census of Assisted Living Program	53

Program History – During the Recertification on-site of 8/1/12, the program received regulatory insufficiencies in the areas of service plan and staffing.

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

A. Other

Complaint/Incident Allegation: It was alleged there was a concern with a tenant who fell.

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4).

  Tenant #1, an 83 year old, was admitted on 7-31-09 and had diagnoses of: Late Effects Cardiovascular Disease, Abnormality of Gait and Depressive Disorder. The service plan dated 12-20-13 indicated Tenant #1 transferred independently. The service plan reflected staff assisted with ambulation in the hallway daily. The service identified Tenant #1 was a high risk for falls.

  According to a detail of event document, on 1-5-14 Tenant #1 activated the pendant and staff responded to find Tenant #1 on the floor between the bed and wheelchair. Tenant #1 had big gashes to the forehead which staff cleansed and applied bandages to. Tenant #1 stated Tenant #1 was fine. A physical/clinical monitoring assessment of Tenant #1 was completed. According to a detail of event document, on 1-28-14 staff found Tenant #1 on the floor at 5:25 p.m. after not being at the supper meal. Staff found Tenant #1 next to the bed and Tenant #1 stated Tenant #1 had fallen out of the wheelchair in the bathroom and crawled to the bed to get the pendant. When Tenant #1 reached for the pendant, it fell under the bed. Tenant #1 had no complaints of pain. According to the detail of event document, on 3-3-14, Tenant #1 slid out of the wheelchair and crawled to the bedroom, attempted to get into bed and sustained

two skin tears. The Patient Care Coordinator said Tenant #1 was not hospitalized or seen in the emergency room (ER) for any of the incidents.

Tenant #2, a 92-year old, was admitted on 1-15-13 and had diagnoses of: Hypertension (HTN), Diabetes Type 2, and Macular Degeneration. Tenant #2 was discharged 2-11-14. The service plan dated 2-3-14 indicated Tenant #2 was independent with transfers and ambulation. The service plan identified Tenant #2 needed to use a walker at all times and was a high risk for falls.

According to a detail of event document, on 1-26-14, staff received a call from an unidentified tenant which indicated Tenant #2 had possibly fallen. Staff responded and found Tenant #2 on the floor of the apartment and Tenant #2 stated his/her legs were very weak. The Patient Care Coordinator stated that Tenant #2 had fallen and was transferred to the hospital where Tenant #2 was diagnosed and treated for a urinary tract infection (UTI). The Patient Care Coordinator also stated that Tenant #2 had a head laceration. Tenant #2 did not return to the Program until 1-30-14. An evaluation of Tenant #2 was completed on 1-30-14. According to a risk events document, on 2-11-14 Tenant #2's family called and said Tenant #2 was on the floor. When staff arrived Tenant #2 stated Tenant #2 went to the bathroom and on the way back Tenant #2 got dizzy and fell. Staff and family thought it would be best to send Tenant #2 to the ER. The Patient Care Coordinator said Tenant #2's family took Tenant #2 to the ER after two "back to back" falls. Tenant #2 was discharged to a nursing home and did not return to the Program.

Tenant #3, a 93 year old, was admitted on 8-15-11 and diagnoses included: HTN, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Tenant #3 was discharged on 1-21-14. According to the service plan with a review date of 2-28-13, Tenant #3 received limited/minimal assistance with transfers and needed assistance twice daily getting in and out of bed. The service plan reflected Tenant #3 had a lift chair and was a high risk for falls. The service plan reflected Tenant #3 mainly used an electric wheelchair but was independent in apartment with a walker. Tenant #3 received assistance once daily with ambulation using a gait belt.

According to a detail of event document, on 1-21-14 Tenant #3 pushed the pendant and staff responded to the call and found Tenant #3 on Tenant #3's stomach facing the window. Staff asked what happened and Tenant #3 said Tenant #3 was getting up to get in the wheelchair and the left arm of the chair broke and Tenant #3 landed on the floor. Tenant #3 hit Tenant #3's head on the television stand and had a big bump on the left side of the forehead. Information from the family after the evaluation in the ER was that Tenant #3 fractured two fingers.

The Patient Care Coordinator said staff called her and she responded to Tenant #3's incident. Tenant #3 told her that Tenant #3 had told family and they were bringing a new chair that day. Tenant #3 had two chairs in the apartment, one in the corner that Tenant #3 sat in and then another chair, which was the one Tenant #3 fell out of at the time of the incident. The left arm of the chair was loose, Tenant #3 went to push up and it gave away. Tenant #3 was laying on Tenant #3's stomach and was rolled over and sat up. Tenant #3 had a goose egg on Tenant #3's head. An ambulance was called and Tenant #3 was seen in the ER. Tenant #3 had a head contusion and fractured fingers. Tenant #3 was transferred to a nursing home. It was the first time

the Patient Care Coordinator was aware the chair arm was loose. She said the tenants furnished their own apartments and if there was an issue with the furniture in the apartment family would be contacted. Staff #1 said Tenant #3 did not tell her the chair was broken and she said other staff was not aware the chair was broken. The Staff Nurse said she first heard the chair broke from the fall and then heard the chair was broken and Tenant #3 fell. The Staff Nurse had no knowledge the chair was broken and she said no staff had knowledge the chair was broken. The Staff Nurse did not have knowledge until after Tenant #3 had been discharged. She said family was the one working on getting Tenant #3 a new chair.

Tenant #4, a 79 year old, was admitted on 5-1-11 and diagnoses included: Asthma, HTN, Generalized Pain and Atrial Fibrillation. According to a service plan document with a most recent review date of 3-14-14, Tenant #4 was independent with transfers, used a walker and received assistance with ambulation to and from meals and activities with the use of a gait belt and walker (as needed per request). According to a detail of event document, on 1-25-14 Tenant #4 pushed the pendant and when staff arrived Tenant #4 was laying on the ground on the left side. Tenant #4 stated Tenant #4 did not think Tenant #4 could get up, was feeling weak and dizzy. Tenant #4 reported Tenant #4 had been sitting in the kitchen chair and fell when Tenant #4 tried to get up. Tenant #4 asked the emergency medical services (EMS) personnel to take Tenant #4 to the ER. The Patient Care Coordinator said Tenant #4 ambulated independently and did not sustain an injury related to the incident. Tenant #4 felt weak and requested to go to the ER. Tenant #4 was admitted to the hospital, went to a nursing home and returned to the Program.

The Patient Care Coordinator said staff received training on falls including: fall prevention, looking out for triggers and hazards. Staff went through a fall competency and then took a quiz. The nurses were called for all falls and staff was trained on system to report falls. There were also monthly programs regarding fall reduction for tenants to attend if they chose to participate.

Review of tenant files, staff interviews and an interview with the Patient Care Coordinator did not reveal concerns as it related to tenant falls.

- Regulatory Insufficiency: None noted.

B. Tenant Documents

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Four tenant files were reviewed (Tenants #1, #2, #3 and #4).

Tenant #1's file was reviewed. According to the detail of event form, on 1-5-14 Tenant #1 activated the pendant and staff responded to find Tenant #1 on the floor between the bed and wheelchair. Tenant #1 had big gashes to the forehead which staff cleansed and applied bandages to. Tenant #1 stated Tenant 1 was fine. A physical/clinical monitoring assessment of Tenant #1 was completed but did not

document the incident or summary in the Clinical Notes. According to a detail of event form, on 1-28-14 staff found Tenant #1 on the floor at 5:25 p.m. after not being at the supper meal. Staff found Tenant #1 next to the bed and Tenant #1 stated Tenant #1 had fallen out of the wheelchair in the bathroom and crawled to the bed to get the pendant. When Tenant #1 reached for the pendant, it fell under the bed. Staff had completed an entry in Clinical Notes. Tenant #1 had no complaints of pain. According to the detail of event form, on 3-3-14 Tenant #1 slid out of the wheelchair and crawled to the bedroom and attempted to get into bed and sustained two skin tears. Staff documented the incident and re-education of Tenant #1 in a notation in the Clinical Notes. Nurse's notes were not documented by exception.

Tenant #2's file was reviewed. According to a detail of event, on 1-26-14 staff received a call from an unidentified tenant which indicated Tenant #2 had possibly fallen. Staff responded and found Tenant #2 on the floor of the apartment and Tenant #2 stated his/her legs were very weak. The Patient Care Coordinator stated that Tenant #2 had fallen and was transferred to the hospital where Tenant #2 was diagnosed and treated for a UTI. The Patient Care Coordinator also stated that Tenant #2 had a head laceration. Tenant #2 did not return to the Program until 1-30-14. An evaluation was completed on 1-30-14 of Tenant #2 but did not document details of the incident in Clinical Notes. The Clinical Notes for Tenant #2 did not document the incident on 1-26-14, hospitalization, treatment of a UTI and a head laceration. Nurse's notes were not documented by exception.

Tenant #4's file was reviewed. According to a detail event document, on 1-25-14 Tenant #4 pushed the pendant and when staff arrived Tenant #4 was laying on the ground on the left side. Tenant #4 stated Tenant #4 did not think Tenant #4 could get up, was feeling weak and dizzy. Tenant #4 reported Tenant #4 had been sitting in the kitchen chair and fell when Tenant #4 tried to get up. Tenant #4 asked the EMS to take Tenant #4 to the ER. The Patient Care Coordinator said Tenant #4 ambulated independently and did not sustain an injury related to the incident. Tenant #4 felt weak and requested to go to the ER. Tenant #4 was admitted to the hospital, went to a nursing home and returned to the Program. Clinical Notes dated 3-14-14 indicated Tenant #4 returned from the nursing home. The Clinical Notes for Tenant #4 did not document the incident that occurred on 1-25-14, the hospitalization and nursing home placement. Nurse's notes were not documented by exception.

Review of tenant files, staff interviews and an interview with the Patient Care Coordinator indicated nurse's notes by exception were not completed.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(i))