IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 51821-C

April 9, 2015

Ms. Kristi Zellmer, Director
Homestead of Knoxville Memory Care
711 South Willetts Drive
Knoxville, IA 50138

RE: Final Complaint/Incident Investigation Report – Homestead of Knoxville Memory Care, Knoxville, IA

Dear Ms. Zellmer:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of April 1 & 2, 2015, 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. Based on record reviews, incident report reviews, medication administration record reviews, policy reviews and staff interviews, the following areas were unsubstantiated:

Allegation: Level of Care
Findings: Unsubstantiated
Comments: Three tenant files were reviewed. None of the tenants met any of the criteria determined for exceeding level of care. Review of incident reports were completed for all three tenants, if incidents had occurred. Staff interviews indicated there were no current tenants who exceeded level of care and none of the three tenants whose files were reviewed had exceeded level of care. The Nurse stated if a tenant exceeded level of care, the Program would not keep the tenant.

The Director was interviewed and stated when tenants were hospitalized; staff would complete an assessment prior to making a decision about the tenants' appropriateness to return to the Program. She stated staff had not yet assessed Tenant #2 while in rehab and no conversations had taken place regarding Tenant #2's returning or not returning to the Program. The Director and Nurse stated they had not talked with a Social Worker at the hospital where Tenant #2 had surgery. The Nurse stated she sent a text to Tenant #2's family to ask about Tenant #2's condition and was informed Tenant #2 had a fractured hip.

Allegation: Nurse Review
Findings: Unsubstantiated
Comments: Clinical Notes from Tenant #2's file were reviewed from 5-28-13 through 10-29-14. Nurse Reviews were completed when indicated and reflected in the Clinical Notes. A Nurse Review was completed on 10-17-14 indicating Tenant #2 had two falls, one on the night of 10-15-14 and the other during the early morning on 10-16-14. The first was at approximately 10:00 p.m. on the 15th. Staff reported hearing the sound of something hitting a cabinet coming from Tenant #2's room. Staff went to check and found Tenant #2 with the lights off, laying of the floor with head against a cabinet in the kitchenette. Tenant #2 stated had tripped over something rubber. Staff did not note anything rubber in the path. Staff reported Tenant #2 had a ping pong ball sized bump on the back right side of head with no other observable injuries noted. Vitals were obtained (T. 98.8 F - BP 134/72 – R 20 – P 90 – Pulse Oximeter 97% RA). With the assistance of two staff, Tenant #2 was assisted up from the floor and to bed. The Nurse was notified of the fall and bump on the back of head. She called and notified family of the event. The second fall occurred at approximately 2:00 a.m. on the 16th. Staff reported hearing a loud noise coming from Tenant #2's room. Staff entered and found Tenant #2 lying on back on the bathroom floor. Tenant #2 was tangled up in the shower curtain and complained of left hip pain. Staff took vitals (T. 97.5 F – BP 164/85 – R 22- P 86 – Pulse Oximeter 96%) and then got Tenant #2 up and walked back to bed. Staff called the Nurse and was notified of the incident (after Tenant #2 was up and in bed). Staff reported Tenant #2 had left hip pain but Tenant #2 had had it since the first fall and was ambulating since. This was the first time the Nurse was told about any hip pain. Tenant #2 slept the rest of the night until the next shift arrived. Staff tried to assist Tenant #2 out of bed at approximately 5:30 a.m. and Tenant #2 was not able to tolerate it as Tenant #2 had left hip pain. Staff notified the Nurse who instructed staff not to move Tenant #2. Family was notified and instructed staff to call 911 for emergency transfer. Tenant #2 was sent to the local emergency room for evaluation and was diagnosed with a left hip fracture. Tenant #2 was transferred to another hospital where plans were to perform surgery.

During an interview with the Nurse on 4-1-15 at 3:30 p.m. she stated staff called her around 10:00 p.m. and notified her of Tenant #2's fall and it appeared Tenant #2 was fine. The Nurse notified family of that fall. Tenant #2 fell again around 2:00 a.m. and staff had already assisted Tenant #2 back to bed before they called the Nurse. The Nurse didn't call family at that time as it appeared Tenant #2 was fine. The day shift staff called the Nurse at 5:30 a.m. and stated Tenant #2 couldn't get out of bed.

Incident Reports and Nurse Reviews for Tenant #2 were documented for falls on: 9-25-13 felt light headed, sat down on bathroom floor and sent to ER; 11-22-13 found on bathroom floor, stated did not fall and no injuries noted; 3-19-14 was found on the floor, transported to emergency room and had a left humerus fracture; 8-10-14 found sitting at the foot of bed, no complaints of pain; 8-23-14 found sitting on the floor in front of couch, no injuries and no complaints of pain, possible Urinary Tract Infection; 10-15-14 found on floor with lights off, hit head on a cabinet and 10-16-14 found lying on back in the bathroom, left hip fracture.

Allegation: Staffing
Findings: Unsubstantiated
Comments: The ALP Monitoring Entrance Form completed by the Program at the time of the onsite visit reflected staffing patterns per shift for the memory care. Five staff were interviewed and indicated there was enough staff to meet the needs of the tenants. All cares were provided as needed and no complaints from tenant families had been received regarding lack of staff to provide cares.

A staff was interviewed who stated she came to work at 5:00 a.m. on the day of Tenant #2's fall that resulted in a hip fracture. She stated the night shift staff reported Tenant #2 had fallen but was asleep. The two staff made rounds and when they arrived at Tenant #2's room, Tenant #2 was awake. They asked if Tenant #2 wanted to go to the bathroom and Tenant #2 stated yes. The walker was put in place and when Tenant #2 put feet on the ground, stated "Oh, my hip hurts" so Tenant #2 was laid back down in bed, the nurse and 911 were called.

The staff who worked the night shift was not able to be interviewed as she no longer worked at the Program.

Hourly Checks for Tenant #2 from 7-1-14 through 10-16-14 were reviewed. Checks every 30 minutes were performed between 10:00 p.m. and 5:00 a.m. every shift. Documentation was completed appropriately.

Allegation: Medication Management
Findings: Unsubstantiated
Comments: Three tenant files were reviewed. Medication Administration Records (MARs) were reviewed as well as Medication Error reports. Tenant #2 had two Medication Error Reports. On 11-26-13, a staff administered a medication that had been discontinued on the MAR. No adverse effect to Tenant #2 was known. On 7-25-14, the Nurse was checking Tenant #2's medications and found the Lamictal was not given on 7-21-14. It was signed out on the MAR. The Nurse spoke to the Medication Manager involved and they both agreed it looked like it had not been given. An exact reason was not determined other than it was probably overlooked. The Medication Manager was re-educated and monitored.

Staff was asked if any tenants had ever gone for six months or longer without receiving a prescribed medication and responded no. The Director and Nurse were asked if any tenants had ever gone for six months or longer without receiving a prescribed medication and they both indicated no.

Staff was asked if the wrong medication list had ever been sent with a tenant going to the emergency room. All staff, the Director and Nurse stated they were not aware of the wrong medication list being sent with a tenant when transferred for emergency care. No evidence of documentation for a different tenant was found in the three tenant files reviewed.

Allegation: DIA Notification
Findings: Unsubstantiated
Comments: According to Tenant #2's service plan dated 5-12-14, Tenant #2 was independent in transfers and ambulated independently with walker. On 4-1-15 at 3:30 p.m. the Nurse was interviewed and stated management had looked into the need to report Tenant #2's fall but due to status of being independent in ambulation, they were not required to report.

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0322	A. BUILDING: _____ B. WING _____	C 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KNOXVILLE MEMORY CARE	711 SOUTH WILLETTS DRIVE KNOXVILLE, IA 50138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 11 Total Population of Program at time of on-site: 12 TOTAL census of Assisted Living Program: 12 No regulatory insufficiencies were cited during the Complaint Investigation #51821-C.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE