IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED
Incident Intake: 29971-I
Complaint Intake: 28623-C

October 29, 2010

Ms. Suzanne Lunsford, Administrator
SunnyBrook Assisted Living of Burlington
5175 West Avenue
Burlington, IA 52601

RE: I. Final Recertification, Incident & Complaint Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Ms. Lunsford:

I. Final Recertification, Incident & Complaint Investigation Report – SunnyBrook Assisted Living of Burlington, Burlington, IA

Enclosed is the **Final Recertification, Incident & Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiency in the area(s) of: Structural Requirements. SunnyBrook Assisted Living of Burlington("Program") is being assessed a $500 civil penalty.

DIA is accepting the Plan of Correction (POC) following the Program's submission of information.

II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send cover letter to the attention of **Tamara Halvorson** and remit the penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0287** with effective dates of **September 23, 2010** through **September 22, 2012.**

V. Conclusion

The Program is being assessed a $500 civil penalty. The POC submitted on September 13, 2010, has been reviewed and will constitute the final POC related to the on-site visit of August 9 & 10, 2010.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to this letter and report, please contact your Certification Coordinator, Tamara Halvorson, at 515/281-5721.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Recertification, Incident & Complaint Investigation Report

Assisted Living Program:

Ms. Suzanne Lunsford, Administrator
Sunnybrook Assisted Living of Burlington
5175 West Avenue
Burlington, IA. 52601

Incident Intake #: 29971-I

Complaint Intake #: 28623-C

Date of Investigations:

August 9 & 10, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC - chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Sunnybrook Assisted Living of Burlington on August 9 & 10, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	53
Current number of tenants with cognitive disorder:	1
Total Population of GPP:	54

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	12
Total Census of ALP:	66

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – A community meeting was held with 37 tenants in attendance. Tenants reported they liked living at the program and were satisfied with the housekeeping and laundry services. Staff were polite, courteous and thoughtful and tenants were receiving the services they expected. Tenants made their own decisions and felt safe living at the program. Tenants enjoyed the variety of food offered and voiced no complaints with the meals. Tenants reported the program offered a variety of activities with plenty of things to do during the day and early evening. Tenants were generally satisfied with the services offered by the program and would recommend the program to their friends and anyone who is considering living at the program.

Program History – There were no Regulatory Insufficiencies found during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Structural requirements

Complaint Allegation #28623-C: It is alleged the program was using an electric griddle to cook bacon and sausage in the dementia unit. A staff observed a tenant in a wheelchair who was adjacent to the electric griddle when it was left unattended.

Monitoring Observation: The Administrator stated the program had used the griddle to cook eggs, bacon and sausage until sometime in April or May, 2010. The Administrator stated on 4-30-10, the State Fire Marshall had inspected the program and advised the program not to cook products containing animal fats in the dementia unit as the unit did not have a proper ventilation and fire suppression system. The program could use the griddle to cook pancakes and waffles that did not contain animal fats. The Administrator stated she instructed staff and the kitchen manager all meats for breakfast would be cooked in the program's main kitchen and not in the dementia unit.

A monitor interviewed three staff. Staff #1 stated the griddle was used in the past, but the State Fire Marshall said not to fry anything on the griddle. When it was used, the griddle was never left unattended. Staff #2 stated the griddle had been used but it wasn't left unattended. The griddle had been used primarily in the morning. If staff had to leave the area they would remove the griddle from the kitchen area and away from tenants. Staff #3 stated the griddle was used until the State Fire Marshall said the program couldn't use it to fry bacon and sausage. The griddle would never have been left unattended.

A monitor toured the dementia unit and made the following observations: Upon inspection of the kitchen area, it was noted an electric griddle had been placed in a bottom cabinet. The electric cord for the griddle was not with the griddle and could not be plugged in and used. The cabinet in which the griddle had been stored was not locked.

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

Upon visual inspection of the dementia unit's kitchen area, a coffeemaker with burner was on and placed on the counter. Adjacent to the coffeemaker was a toaster oven and an electric toaster. Both appliances were plugged in and ready to use.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35 (1))

B. Other

Incident Allegation: The program reported Tenant #1 became stiff, clenched his/her hands and fell to the floor onto his/her face. Emergency 911 was called and the program's registered nurse (RN) immediately applied pressure to the tenant's head until an ambulance arrived. The tenant was transported to a local hospital emergency room for treatment.

Monitoring Observation: The tenant was an 88 year old, admitted on 11-20-09 and had diagnoses of: History of Trans Ischemic Attacks (TIA), History of Cerebral Vascular Accident, Wernicke's Aphasia, Urinary Tract Infection, Atrial Fibrillation, History of Right Hip Fracture, History of Bilateral Knee Replacement, History of Bilateral Mastectomy due to Breast Cancer and Hypertension. A Global Deterioration Scale

completed on 5-7-10 staged the tenant at three which indicated mild cognitive decline. The tenant resided in the general population.

Nurse's notes of 2-16-10 indicated the tenant reported he/she had fallen. A nurse review was completed by an RN. Nurse's notes of 4-19-10 indicated the tenant had fallen, losing his/her balance. The program completed a nurse review. Nurse's notes of 5-5-10 indicated the tenant was ambulating with staff when the tenant became weak and had to sit down. The tenant started to shake and became rigid. An RN found the tenant non-responsive. The tenant was transported to a hospital emergency room. Hospital staff notified the program the tenant was admitted to the hospital with a diagnosis of TIA. Nurse's notes of 5-7-10 indicated the tenant returned to the program after being discharged from the hospital. Functional, cognitive and health evaluations were completed. The tenant's service plan was updated on 5-7-10 and indicated the tenant was independent with ambulation, with the tenant using his/her pendent when assistance was needed, due to the tenant's difficulty with speech. The tenant was independent with eating and staff were to check on the tenant several times a shift for two weeks following his/her hospitalization.

Nurse's notes of 8-4-10 indicated the program's RN responded to staff's call for assistance. The tenant had lost consciousness and fell off a dining room chair and hit his/her head on the floor. The RN found the tenant on the floor and the tenant's head was severely bleeding. The tenant was rigid, fists were clenched and the tenant was shaking. The tenant had labored breathing, was unconscious and had no response to verbal stimuli. The RN immediately held pressure to the tenant's head. Emergency personnel were called and the RN continued to hold pressure to the tenant's bleeding head wound until emergency personnel arrived. Nurse's notes of the same entry indicated other tenants sitting around the tenant witnessed the tenant become stiff, clenched his/her hands and fell to the floor. Hospital documentation indicated the tenant passed away later that day.

Staff #1, #2 and #3 stated the tenant could ambulate independently with the assistance of a walker and was independent with eating.

- Regulatory Insufficiency: None noted.

Dated this 18th day of August, 2010.