IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Incident Intake: 31511-I

December 15, 2010

Ms. Suzanne Lunsford, RN Manager
SunnyBrook of Burlington
5175 West Avenue
Burlington, IA 52601

RE: Final Incident Investigation Report – SunnyBrook of Burlington, Burlington, IA

Dear Ms. Lunsford:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of November 30, 2010, 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 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program: **Incident Intake #: 31511-I**

Suzanne Lunsford, RN Manager
SunnyBrook of Burlington
5175 West Avenue
Burlington, IA 52601

Date of Incident Investigation:

November 30, 2010

Monitor(s):

Stephanie Cummins, MA

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 of Burlington on November 30, 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:	49
Current number of tenants with cognitive disorder:	4
Total Population of GPP:	53

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

Total Population of DSP:	8

Total Census of ALP: 61

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

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. Staffing

Incident Allegation: The program reported a tenant returned to the program from a stay at a Hospice House for increased weakness. The tenant was assisted with nighttime cares by program staff. The tenant was checked on frequently throughout the night by program staff. It was reported by the program, at approximately 6:00 a.m. the Hospice Home Health Aide (HHA) noticed the tenant's oxygen was not on the tenant. The HHA checked the tenant's oxygen sats and they were 71% and the tenant's normal range was in the low 80's. The HHA reported it to the Home Health Nurse and the program nurse was notified. It was reported the tenant's doctor was not notified at that time. The program nurse checked on the tenant and the tenant was alert, complained of neck pain; however, did not complain of shortness of breath. Later that day the tenant began having gurgling secretions and Atropine drops were started. The tenant declined and died the following day.

- Monitoring Observation: Tenant #1's file was reviewed. According to Nurse's Notes dated 10-8-10 the tenant was transferred to Hospice House due to increased weakness and family request. The tenant returned on 10-12-10. Nurse's Notes On 10-20-10 at 8:45 a.m. staff reported the Hospice HHA found the tenant without oxygen on during the night. Staff #1 and #2 worked on second shift on 10-19-10 and Staff #3 worked third shift on 10-19-10 into 10-20-10. The Hospice HHA reported to Staff #4 who worked first shift on 10-20-10, that the tenant was found not wearing oxygen. Staff #1, #2, #3 and #4 were interviewed and provided written statements. The following information was gathered from those interviews and statements.

  Staff #1 worked second shift on 10-19-10. She indicated she administered the tenant's oral medications and returned after the tenant's visitors had left and assisted the tenant with getting the breathing treatment ready at approximately 7:00 to 8:00 p.m. The tenant told her she did not ever need to wait and just to do what she needed to do. She assisted the tenant with his/her breathing treatment and the tenant dropped it approximately three to four times. She wheeled the tenant to the sink and the tenant started his/her nighttime cares. The tenant seemed "out of it" according to the staff. She then took off the tenant's oxygen and put it on the tenant's bed. The tenant complained of neck pain. She looked at the tenant's neck and the tenant's pendant had left a red mark on the tenant's neck. The tenant told staff to put the pendant on the bedside table. Staff put the pendant on the bedside table and rubbed the tenant's neck with cream. Staff started assisting the tenant with dressing/undressing and the tenant indicated he/she wanted to wear the same outfit that he/she had on for the next day. The tenant told her to lay the clothes on the couch. She assisted the tenant with dressing and called for Staff #2 to assist with boosting the tenant up in bed. Staff #2 came in to assist with boosting the tenant up in bed and then he left. She stated she put the tenant's oxygen back on the tenant, then went to the medicine cabinet to get the tenant's eye drops and eye ointment. She administered the eye drops and raised the head of the tenant's bed because it sounded like the tenant was gurgling. She indicated the tenant's breathing was not labored and not out of the ordinary and described it as congested. The bedside table was up against the tenant's bedrail and the pendant was closest to him/her beside the tenant's cell phone. She indicated she put the pendant where the tenant could reach the pendant. Staff gave the tenant a box of tissues and set them in the bed beside the tenant. She shut off the light and signed

off in the Medication Administration Records (MARs). She shut off the living room lights and left shutting the door behind her. She estimated she left the tenant's room at approximately 8:30 to 9:00 p.m. and the tenant was going to bed at that time.

Staff #2 worked second shift on 10-19-10. He stated he helped another staff get the tenant into bed. Staff #2 stated he would assume the oxygen was on; however, he could not guarantee it. He stated he went into the tenant's apartment at 10:00 p.m. and he believed the tenant's oxygen was on at that time. He stated he was not in the tenant's apartment a lot that night. He reported there was nothing abnormal with the tenant's breathing. He stated he remembered the tenant coming out to the dining room for supper at approximately 4:45 to 5:00 p.m. He helped the tenant from the dining room to the tenant's apartment and shortly after that comforted him/her in bed. The tenant was tired but very cooperative, talkative and appropriately mannered, according to Staff #2.

Staff #3 worked third shift on 10-19-10 into 10-20-10. She periodically checked in on the tenant and the tenant was sleeping and snoring lightly. She checked on the tenant approximately three to four times during the night. The tenant's breathing was fairly rhythmical and not harsh or wheezy. The tenant's apartment was fairly dark and she stood inside the doorway of the bedroom. The tenant's oxygen machine was on; however, she did not observe if the tenant was wearing it. She indicated the tenant was very diligent about wearing the oxygen at all times. At 5:00 a.m. she gave the tenant his/her morning medications and breathing treatment. She was in and out of the tenant's apartment and did not recall if the tenant had oxygen on. She did not remove it from the tenant's face as the tenant was very careful to always have it with him/her. The tenant was a little congestive and coughed which was usual for the tenant in the morning. The tenant was alert and asked about getting a bath. She told the tenant that the bath aide was scheduled to arrive at 6:00 a.m. She asked if the tenant needed anything and if there was anything else she could do for the tenant. The tenant replied he/she did not need anything at that time. She left the apartment. She said she there was nothing unusual and the tenant seemed fine. She reported there were no issues with the tenant's breathing and she did not have any concerns or she would have reported it to the nurse.

Staff #4 worked first shift on 10-20-10. She indicated she had just clocked in to work at 6:00 a.m. The Hospice HHA asked her how long the tenant had been without oxygen. She stated she did not know and she had just arrived at work. She asked Staff #3 how long the tenant had been without oxygen. Staff #3 stated it was on when she gave the tenant medications at 5:00 a.m. She asked if she was sure because the Hospice HHA said the oxygen was on the couch when she arrived. Staff #3 said maybe she heard the machine running and assumed it was on the tenant. Staff #4 went to check on the tenant. The tenant grabbed her hand and asked what they were trying to do to him/her. She asked the tenant who he/she was referring to and the tenant reported the night shift people left the oxygen off all night. She assured the tenant that she did not think anyone was trying to hurt the tenant. She stated the Hospice HHA checked the tenant's oxygen saturation. The Hospice HHA had put the oxygen back on the tenant right away. The tenant's breathing was shallow; however, that was normal for the tenant. She checked on the tenant every 15 minutes and the tenant knew who she was each time. The tenant asked for his/her cell phone and dialed the phone independently. The tenant seemed calmer afterwards.

The Hospice HHA was interviewed. She came in at approximately 6:00 a.m. and the oxygen machine was running; however, the oxygen was not on the tenant. The tenant was awake and told her no one put oxygen on him/her last night. The tenant requested the HHA take his/her oxygen saturation level. She reported the tenant's oxygen saturation level was at 73% and the tenant did not look or appear any different. She asked the tenant why the tenant had not called for assistance and the tenant reported he/she had taken the pendant off and could not reach it. She put the oxygen back on the tenant and notified staff that the tubing was found on the couch with clothing. She notified the Hospice nurse. She said the pendant was on the bedside table and had the tenant rolled over he/she could have reach it. She was not sure if the tenant could roll over. She stated the tenant was always short of breath and was no worse than normal.

Review of a Personal Emergency Response System (PERS) printout indicated the tenant's pendant was activated on the night of 10-19-10 and on 10-20-10. Staff #1, #2, #3 and #4 reported the tenant was able to use the PERS.

The tenant's service plan indicated staff assisted the tenant with changing the regulator on top of the portable oxygen tank and the tenant would notify staff when that was needed. The tenant requested staff check with the tenant daily to see if it needed changed as the tenant did have some difficulty seeing the gauge.

The Hospice Nursing Visit assessment completed on 10-18-10 indicated the tenant's oxygen saturation was at 77%. The Hospice Nursing Visit Assessment dated 10-20-10 indicated the tenant's oxygen saturation was at 87%.

According to Nurse's Notes the nurse was informed the tenant was found not wearing oxygen on 10-20-10 at 8:45 a.m. The nurse checked on the tenant at 9:00 a.m. and the tenant was resting in bed and reported he/she was not doing well. The tenant complained of neck pain; however, did not mention any dyspnea. The note indicated the tenant had a breathing treatment prior to the nurse's visit. The nurse did not indicate if the tenant's oxygen saturation level was taken and the tenant's physician was not notified of tenant found without oxygen. Nursing services were not provided in accordance with Chapter 6.

- Regulatory Insufficiency: None Noted.

Dated this 15th day of December 2010.