IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

January 18, 2011

Incident Intake #: 32089-I
31621-I

Ms. Amy VanderVaart, Administrator
Brook View Senior Living
2903 F Avenue NW
Cedar Rapids, IA 52405

RE: Final Incident Investigation & Recertification Monitoring Evaluation Report – Brook View Senior Living, Cedar Rapids, IA

Dear Ms. VanderVaart:

Enclosed is the **Final Incident Investigation & Recertification Monitoring Evaluation 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.

DIA has completed the review of your Plan of Correction (POC) in response to the Preliminary Incident Investigation & Recertification Monitoring Evaluation Report. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiency, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0277** with effective dates of **June 20, 2010** through **June 19, 2012.**

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation & Recertification Monitoring Evaluation Report

Assisted Living Program:

Amy VanderVaart, Administrator
Brookview Senior Living
2903 F Avenue NW
Cedar Rapids, IA 52405

Incident Intake #: 32089-I
31621-I

Date of Incident Investigation:

December 9, 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 Brookview Senior Living on December 9, 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:	36
Current number of tenants with cognitive disorder:	2
Total Population:	38

Dementia Specific Program (DSP)* – Not applicable.

***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 with 14 tenants was held. The tenants did not have concerns with housekeeping. They stated staff needed additional training to fold bed linens and clothing properly. The tenants also requested staff received training to appropriately make a bed. They received the nursing services they required and staff responded in approximately five to ten minutes when they called for assistance. One tenant stated staff responded in less than three minutes when he/she called at night. The tenants requested improved communication and also requested a clarification on the lights by the apartment doors. The tenants requested more variety of foods and stated there were too many soups served. The temperature of the hot food needed to be improved and they requested more diabetic food options. One tenant reported the tray meal service had improved recently. There were sufficient activities offered and they enjoyed the activities offered. The tenants felt safe; however, two tenants requested a volunteer sit at the reception area when it was not attended by staff. The tenants made their own decisions and they were satisfied living at the program. The tenants stated they would recommend it to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Transportation

- Monitoring Observation: The program had a bus that had capacity for less than 16 passengers. A tour of the bus indicated there were not seatbelts for the passengers.

- Regulatory Insufficiency: Vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers. (IAC r. 481-69.33(3))

B. Other

Incident Allegation #31621-I: The program reported a tenant reported he/she was missing Hydrocodone/Apap 2.5/500 mg. It was reported the tenant self-administered his/her medications.

- Monitoring Observation: Tenant #1, an 83 year old, was admitted on 1-13-09 and diagnoses include: Atrial Fibrillation, Hypertension (HTN), Hyperlipidemia, Diabetes, Congestive Heart Failure (CHF), Wolff Parkinson White Syndrome with Ablation, Stage 3 Kidney Disease, Bone Paget Disease, Peripheral Vascular Disease (PVD), Osteoporosis, Esophageal Stricture, Anxiety and Hypothyroidism. The tenant did not receive any personal or health related care services and was independent with medication administration. The tenant was prescribed Hydrocodone/Apap 2.5/500 mg by mouth four times daily.

  According to an Accident/Incident Report, the tenant reported to the Administrator that he/she was missing some pain medication. The tenant was unsure of the exact amount missing; however, noticed a decrease of five or more over a week and prior to that possibly a significant amount. The tenant did not maintain a log and there was not a way to determine the exact amount of medication missing. The local police department was called and the department was notified. Staff were interviewed and the tenant was encouraged to purchase a lock box. The program also offered to assist the tenant with medication administration. The tenant declined both the lock box and program assistance with medication administration.

  The Administrator, the Administrative Assistant, the nurse, the housekeeper and universal workers working on each shift had keys to tenant apartments, according to the Administrator. She stated the doorway between the program and two other programs was open to tenants, visitors and staff. The Administrator indicated there had not been any unusual visitors in the building and there had not been a person identified who took the missing medications.

  Staff #1 and #2 did not know who had taken the tenant's medications.

  At the time of the investigation, it could not be determined who took the medications.

- Regulatory Insufficiency: None noted.

Incident Allegation #32089-I: The program reported a tenant reported he/she was missing Darvocet between October 28, 2010 and November 11, 2010. It was reported the tenant self-administered his/her medications.

- Monitoring Observation: Tenant #2, a 97 year old, was admitted on 10-25-08 and had a diagnosis of Arthritis. The tenant did not receive any personal or health related care services and was independent with medication administration. The tenant was prescribed Darvocet 100/650 mg three to four times daily.

  According to an Accident/Incident Report, the tenant reported to the nurse that he/she was missing some pills and believed that someone may had taken the medication. The tenant reported he/she had a prescription of 100/650 mg Darvocet four times daily filled on 10-28-10. The tenant reported the medication may have been missing between 10-28-10 and 11-11-10 and the tenant noticed he/she was low on medication on 11-11-10. The tenant also reported he/she had accidentally dropped the medication planner in the sink. The tenant thought he/she heard someone in his/her apartment and heard the door close during this time period. The tenant felt like there was someone in his/her apartment. The program encouraged the tenant to purchase a lock box.

  The Administrator, the Administrative Assistant, the nurse, the housekeeper and universal workers working on each shift had keys to tenant apartments, according to the Administrator. She stated the doorway between the program and two other programs was open to tenants, visitors and staff. The Administrator indicated there had not been any unusual visitors in the building and there had not been a person identified who took the missing medications.

  Staff #1 and #2 did not know who had taken the tenant's medications.

  At the time of the investigation, it could not be determined who took the medications.

- Regulatory Insufficiency: None noted.

Dated this 12th day of January , 2011.