IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

March 7, 2011

Ms. Valerie Lybarger-Adams, Manager
Sunnybrook of Fairfield
3000 West Madison Avenue
Fairfield, IA 52556

RE: Final Incident Investigation & Recertification Monitoring Evaluation Report – Sunnybrook of Fairfield, Fairfield, IA

Dear Ms. Adams:

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. **No Regulatory Insufficiencies were found during this evaluation.**

The review of the recertification documents you submitted has been completed and 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 **S0170** with effective dates of **February 19, 2011** through **February 18, 2013**.

If you have any questions regarding 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:

Incident Intake #: 31753-I

Valerie Lybarger-Adams, Manager
Sunnybrook of Fairfield
3000 West Madison Avenue
Fairfield, IA 52556

Date of Incident Investigation & Monitoring Visit:

December 21, 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 Fairfield on December 21, 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:	52
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	55

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

Total Population of DSP:	11
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 with 23 tenants was held. The tenants did not have any concerns with housekeeping or laundry. They said the maintenance staff did a great job; however, there were concerns about the water pressure and odors from drains in some apartments. The tenants acknowledged they had reported these concerns and the program was working on the issues. Nursing services were available as needed and staff responded within minutes when tenants called for assistance. The tenants were getting what was promised when they moved in and stated they made their own decisions. They described staff as excellent and great and stated staff knocked before entering their apartments. The staff were trained and the tenants received all the services they requested. The tenants requested more variety of vegetables and said the meats were tough. They stated the temperature of the food was not consistently hot at the noon and evening meals. One tenant requested the lettuce and vegetables in the salads be cut into small pieces. The tenants were satisfied with the activities offered and said they received an activity calendar. They said the activity staff did a great job and there were no improvements needed with activities. The tenants enjoyed Bingo and the recent trip to observe holiday lighting displays. The tenants felt safe and they were satisfied living at the program. They would recommend it to others and enjoyed the friendly staff and tenants. The tenants also enjoyed not being alone and having fewer responsibilities.

Program History – There were substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plans, Medications and Staffing.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas. **There were no regulatory insufficiencies found during this onsite recertification monitoring evaluation.**

A. Other

Incident Allegation: The program reported a tenant fell and hit his/her head and was bleeding from the back of the head. It was reported the nurse applied direct pressure while staff called 911. It was reported the tenant was transported to the Emergency Room (ER) and had staples in the back of the head.

- Monitoring Observation: Tenant #1, an 89 year old, was admitted on 12-10-08 and diagnoses include Generalized Anxiety Disorder, Dementia, Hypertension (HTN), Osteoporosis and Gastro Esophageal Reflux Disease (GERD). The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The tenant resided in the dementia unit. The tenant was discharged on 11-21-10.

  According to an Event Report dated 11-3-10 at 5:20 p.m., the tenant was in the dining room area by the table in the dementia unit. Staff was scraping a plate and turned around and the tenant was lying on the floor. The nurse was notified and she came to assess the tenant. The nurse held towels under the tenant's head to stop the bleeding. The tenant's vitals were taken and an ambulance was called. The tenant's family was also notified. The tenant was taken to the ER and the tenant had staples to the back of the head. Review of Event Reports from 10-1-10 to 10-30-10 indicated the tenant had fallen four times; however, did not have any significant injuries.

  Review of the tenant's file indicated cognitive, health and functional evaluations were completed and the service plan was updated on 11-2-10. The update reflected Physical Therapy (PT) services. The service plan addressed the tenant had decrease in mobility at times with falls and needed reminders to operate wheeled walker.

  The nurse said staff notified her that the tenant had finished supper and went to leave with his/her walker and fell straight back and hit his/her head. Staff notified the nurse, who was in the building at the time of the incident. She assessed the tenant and the tenant was awake and alert and was lying flat on his/her back. The nurse stated the tenant did not lose consciousness. The nurse applied pressure to the back of the tenant's head with towels and instructed staff to call 911. Staff took vitals and the nurse stayed with tenant and continued to apply pressure. The ambulance arrived in approximately seven minutes, according to the nurse. The tenant was taken to ER and was admitted for observation. The tenant received staples to the back of the head and did not have any other injuries. The tenant did not return to the program from the hospital. The nurse felt the situation was handled appropriately. The nurse stated prior to the incident there had been conversations with the tenant's family regarding behaviors and alternative placement. After the incident the tenant's family decided to transfer the tenant to a higher level of care and gave notice to the program.

  The program completed an incident report related to the incident and notified the department appropriately.

- Regulatory Insufficiency: None noted.

Dated this 23rd day of December, 2010.