IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

March 8, 2011

Bruce Boehm Jr. Administrator
Sunnybrook of Carroll
1214 East 18th Street
Carroll, IA 51401

RE: Final Complaint, Incident and Recertification Monitoring Evaluation Report – Sunnybrook of Carroll, Carroll, IA

Dear Mr. Boehm:

Enclosed is the **Final Complaint, Incident and 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 Complaint, Incident and Recertification Monitoring Evaluation Report. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, 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 **S0285** with effective dates of **September 10, 2010** through **September 9, 2012**.

If you have any questions in regard to this certification, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint, Incident and Recertification Monitoring Evaluation Report

Assisted Living Program:

Complaint Intake #: 32287-C
32414-C
32233-I

Bruce Boehm Jr. Administrator
Sunnybrook of Carroll
1214 East 18th St.
Carroll, IA 51401

Date of Investigation:

January 24, 25 and 26, 2011

Monitor(s):

Joyce Kix, RN
Maribeth Freland, RN

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 a Complaint 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:

A complaint investigation on-site visit was conducted at Sunnybrook of Carroll on January 24, 25 and 26, 2011. In preparing this report, the following information was considered:

Current Program Census:

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

Current number of tenants without cognitive disorder:	34
Current number of tenants with cognitive disorder:	3
Total Population of GPP:	37

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:	45

***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 announced to the tenants for 1:00 p.m. however, only one tenant arrived for the meeting. Several other tenants were interviewed individually. The tenants were very happy with the program. They reported the staff was friendly and responded to requests for help promptly. They stated the food was good and they would recommend the program to others.

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

On-Site Monitoring Evaluation – The monitors made the observations detailed in the following areas.

A. Evaluation of Tenant

Monitoring Observation: Tenant #1, an 81 year old, residing in the dementia unit, was admitted on 10-8-10 with diagnoses of: Senile Dementia, Diabetes and History of Atrial Fibrillation. On 10-29-10, the tenant was staged at 5 on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

On 10-5-10, the nurse completed a pre-admission health evaluation. The evaluation form required the nurse to obtain vital signs, including temperature, pulse, respirations, blood pressure and weight. The form completed by the nurse lacked an evaluation of any of the above stated vital signs.

On 10-28-10 at 2:00 am, staff found the tenant to be difficult to arouse with a pulse rate of 44 beats per minute. After failed attempts to arouse the tenant, staff sent the tenant to the emergency room for medical evaluation. The tenant was subsequently admitted to the hospital for observation.

On 10-29-10, upon the tenant's return to the program, the nurse completed a health evaluation. The evaluation form required the nurse to obtain vital signs, including temperature, pulse, respirations, blood pressure and weight. The form completed by the nurse lacked an evaluation of any of the above stated vital signs.

The nurse failed to assess all components identified by the program as required when completing the health evaluation.

Tenant #3, an 87 year old, was admitted on 3-23-10 with diagnoses of: History of Myocardial Infarction, Pneumonia and Osteoporosis. On 1-3-11, the tenant was staged at 1 on the GDS, which indicated no cognitive decline.

According to the Incident Report, dated 1-2-11, staff found Tenant #3 lying on the floor in his/her bathroom. The tenant sustained a four centimeter laceration to the left side of the head and reported pain to his/her right arm. Staff called the tenant's family, who transported the tenant to an emergency room.

The Nurse Narrative Note, dated and signed by Staff #4, a registered nurse (RN), on 1-3-11 at 7:50 am, indicated the tenant had been sent to the emergency room on 1-2-11 at 2:00 am following a fall which resulted in a head laceration. Staff #4, RN, documented the tenant continued to complain of headaches and right arm pain, which increased with movement. The nurse noted the tenant's right arm to be bruised and swollen. The tenant "became teary eyed due to pain." The nurse did not document evaluation of vital signs, neurological evaluation or a pain evaluation.

The note indicated the tenant's family member reported the emergency room x-rayed the right arm, finding no apparent fracture. The family member reported a plan to take the tenant to his/her primary care physician later in the day, as the tenant continued to complain of pain in the right arm.

The Nurse Narrative Note, dated 1-3-11 at 1:45 pm, indicated the tenant returned to the program with his/her right arm wrapped with an elastic bandage and placed in a sling for comfort.

On 1-3-11 at 4:00 pm, the nurse completed a health evaluation. The evaluation form required the nurse to obtain vital signs, including temperature, pulse, respirations, blood pressure and weight. The form completed by the nurse lacked an evaluation of any of the above stated vital signs.

The nurse failed to adequately assess the tenant's health status needs following the tenant's head injury and failed to assess all components identified by the program as required when completing the health evaluation. The tenant subsequently died at 6:32 PM on 1-3-11.

Tenant #5, a 92 year old residing in the dementia unit, was admitted on 2-5-09 with diagnoses of: Mild Dementia, History of Urinary Tract Infections and Hypothyroidism. On 10-21-10, the tenant was staged at 5 on the GDS, which indicated moderate severe cognitive decline.

The tenant's clinical record documented the tenant experienced an exacerbation of lymphoma, resulting in blistered, weeping sores on the shins. On 10-21-10 the nurse completed a health evaluation due to the tenant's change in skin condition. The evaluation form required the nurse to obtain vital signs, including temperature, pulse, respirations, blood pressure and weight. The form completed by the nurse lacked an evaluation of any of the above stated vital signs.

The nurse failed to assess all components identified by the program as required when completing the comprehensive health evaluation.

According to the Incident Report, dated 1-3-11 at 12:45 pm, staff found Tenant #5 lying on the floor in the dementia unit's hallway, bleeding from the back of the head. The tenant exhibited an approximate 2 inch laceration to the back of his/her head. Staff called 911 to transport the tenant to an emergency room.

The Nurse Narrative Note, dated 1-3-11 at 2:15 pm and signed by Staff #4, indicated the tenant returned to the program with five staples approximating the tenant's head wound. The nurse documented no changes in the tenant's cognitive, health or functional status at this time.

The Nurse Narrative Note, dated 1-6-11 at 2:15 pm, indicated that earlier in the morning, staff had found the tenant in the dementia unit dining room on the floor weak and lethargic. Staff notified the tenant's family member who subsequently transported the tenant to the emergency room. Upon return to the program, the family member reported tests had been completed with no cause found for the tenant's lethargy. The family reported emergency room personnel directed he/she report any new signs. The nurse documented no changes in the tenant's cognitive, health or functional status.

The Service Plan, dated 10/21/10, indicated Tenant #5 was independent with showering, dressing and grooming.

The tenant's clinical record contained a behavior sheet documenting the following behaviors for Tenant #5: 1-6-11 at 4:30 pm: Staff found the tenant in his/her shower "looking very scared". The tenant's hands were very cold. On 1-7-11 at 7:00 pm: Staff found the tenant undressing in another tenant's room. Tenant became frustrated and unable to express frustration verbally. On 1-8-11 between 3:00 pm and 5:00 pm: The tenant attempted to rearrange his/her room and got very confused. On 1-9-11 on 2-10 shift the tenant showed an increase in agitation exhibited toward other tenants throughout the shift. On 1-13-11 at 12:15 pm: The tenant put toothpaste on his/her comb and evaluation despite the changes in the tenant's behavior and functional abilities following the tenant's head injury.

The nurse failed to complete cognitive, health and functional evalutions with significant changes in the tenant's behavior following the tenant's head injury.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Medications

Complaint Allegation #32287-C and #32414-C: It was alleged that there were errors in medications and documentation. It was alleged that staff administered medication to a tenant without physician's orders.

Monitoring Observation: Documentation provided by the program indicated 16 medication error reports had been completed during the past three months.

During interview on 1-25-11 the nurse reported Tenant #3 administered his/her own medications and the program was not aware of his/her physician's orders.

During interview, Staff #1, a universal worker, reported that he observed Tenant #3 take what appeared to be two 500 milligram (mg) tablets of Tylenol left out by the tenant's family to be taken at 2:00 am on 1-2-11. Staff #1 reported the tenant continued to complain of intense pain at around 3:30 am. He called Staff #8, RN, to report Tenant #3's pain. Staff #1 reported he gave Tenant #3 two 500 mg tablets of Tylenol from the program's stock of medication on 1-2-11 at approximately 3:30 am per the RN's direction. Staff #1 stated he took the bottle of Tylenol to the room and dispensed two tablets into a medication cup and gave them to the tenant. Staff #1 made no documentation of the administration of the Tylenol because there was no medication administration record (MAR) for Tenant #3 on which to document.

During interview, Staff #8, RN, reported she received a call from Staff #1 sometime between 2:00 am and 4:00 am. Staff #1 reported Tenant #3 was in pain and was requesting medication for the pain. The nurse did not know what medications the tenant took nor had physician orders for as the program did not assist the tenant with

medications and did not have a medication list. The nurse reported telling Staff #1 to take the program's bottle of 325 mg tablets, kept for staff use, to the tenant so the tenant could use at his/her discretion. The nurse indicated this was not her usual practice and told Staff #1 to never do it again. Staff #8 denied being told that the tenant had already taken two 500 mg tablets of Tylenol at 2:00 pm.

According to the medication list obtained by the program on 1-26-11, Tenant #3's order was for 325 mg of Tylenol not 500 mg. Staff #1 gave additional mg. of Tylenol without a physician's order and exceeded the manufacturer's recommended dosage of two 500 mg tablets every six hours.

Tenant #12, a 93 year old, was admitted 10-9-10 with diagnoses of: Arthritis, Hyperlipidemia, Hypertension, and Colon Cancer. The service plan of 1-5-11 documented the program provided medication management for the tenant. Review of the MAR revealed a self adhesive note attached, signed but not dated by the nurse, which directed staff to administer Albuteral nebulizers (aerosol treatment) four times a day The physician's order directed for the treatment to be given four times a day only as needed. The MAR documented administration of the nebulizers two to four times a day since 1-19-11. During interview, the nurse stated the physician had suggested the program increase the nebulizer treatments for a week to evaluate if it would help the tenant with his/her breathing. The nurse stated she did not document the conversation with the physician and did not obtain an order.

- Regulatory Insufficiency: The administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6) a.)

C. Nurse Review

Monitoring Observation: According to the Incident Report, dated 1-2-11, staff found Tenant #3 lying on the floor in his/her bathroom. The tenant sustained a four centimeter laceration to the left side of the head and reported pain to his/her right arm. Staff called the tenant's family, who transporting the tenant to an emergency room.

The Emergency Department Flow Sheet, dated 1-2-11, indicated the tenant arrived at 4:00 am and left at 7:20 am on 1-2-11.

The tenant's clinical record lacked any nurse documentation related to the fall or the tenant's condition for the first 24 hours following the tenant's return to the program.

Review of the staff schedule revealed, Staff #1, universal worker, and Staff #5, certified nurse aide, worked the night shift on 1-2-11 following Tenant #3's return from the emergency room. Both staff reported the tenant used the emergency call system several times during the night, which was unusual. Throughout the night, the tenant reported a pain level of nine or ten on a one to ten scale with ten being the most severe pain the tenant had ever experienced. Both staff reported the tenant was crying and requested medication for the pain. Staff #1 reported he had contacted Staff #8, a corporate registered nurse taking call for the program during the night of 1-2-11, to report the

tenant's pain and request pain medication. Staff #1 reported the nurse instructed him to give the tenant Tylenol for pain.

The clinical record included a Nurse Narrative Note , dated 1-3-11 at 7:50 am and signed by Staff #4, RN, documenting the tenant's fall and transfer to the emergency room on 1-2-11 and the tenant's current condition. The note lacked any indication of the tenant's health status throughout the previous night and early morning hours. The nurse documented the tenant currently complained of headache and right arm pain, which increased with movement. The nurse noted the tenant's right arm to be bruised and swollen. The tenant "became teary eyed due to pain". The nurse did not document any evaluation of vital signs, neurological evaluation or a pain evaluation. The tenant subsequently died at 6:32pm on 1/3/11.

The nurse failed to document the tenant's health status and any directives given to staff during the early morning hours of 1-3-11.

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

D. Staffing

Complaint Allegation #32287-C: It was alleged staff did not receive appropriate training and delegation for medication administration.

Four personnel records of staff that provided medication administration were reviewed. All contained appropriate documentation of nurse delegation for medication administration.

- Regulatory Insufficiency: None Noted.

E. Tenant Rights

Complaint Allegation #32287-C and #32233-I: It was alleged and the program reported that three tenants reported missing property. It was alleged a staff member was sexually inappropriate, verbally unkind and physically rough with one tenant. It was alleged three tenants refused to allow the staff member to care for them due to inappropriate overtures and one family member requested the same staff member not care for his/her family member. It was alleged tenants in the dementia unit were required to receive bathing assistance at abnormally early hours of the morning.

Monitoring Observation: Tenants #7 and #10 were interviewed and reported money missing from their rooms in the past. Tenants #4, #6 and #12 reported no concerns regarding missing money or possessions. One family member was interviewed and reported no concerns regarding missing money or possessions.

The program, the police and the monitor's investigation into the missing money determined the thefts had most likely occurred; however, a specific perpetrator could not be identified.

Twelve tenant clinical records were reviewed. The records contained no documentation indicative of injuries resulting from inappropriate staff interactions. Incident reports for the past three months were reviewed. The reports documented no injuries of unknown etiology or injuries due to staff/tenant interactions.

The monitors reviewed the clinical record of the tenant identified in the complaint as sustaining bruises due to rough treatment by staff. The tenant's clinical record showed no indication of bruises indicative of purposeful injury. The monitors made multiple observations of the tenant and observed no unusual bruising or injuries.

Multiple tenants and family members were interviewed. No one reported experiencing or witnessing rough or unkind treatment by staff. No one witnessed any inappropriate treatment toward tenants unable to speak for themselves.

The monitors interviewed four staff members with no reports of witnessed rough or sexually inappropriate staff interaction. The monitors interviewed the three tenants and the one family member identified as refusing care from staff due to inappropriate overtures. All denied any concerns with the staff member identified or any other staff.

The monitors interviewed two night shift staff at 12:00 midnight. Both denied routinely giving showers on their shift unless tenants were soiled and required care. The monitors reviewed the clinical records of four tenants residing in the dementia unit finding no evidence of bathing assistance which routinely occurred on the night shift or at unusual hours.

- Regulatory Insufficiency: None noted.

F. Other

Complaint Allegation #32287-C: It was alleged that staff was sleeping while on duty.

Monitoring Observation: The Director provided documentation of intervention with Staff #1 dated 12-16-10 which indicated the staff person had been reported sleeping or lying on the couch while on duty.

During interview on 1-25-11, Staff #5 reported that on 1/2/11, Staff #1 left the dementia unit unattended and came to the front at about 4:15 a.m. Staff #5 did not know why Staff #1 left the unit; however, both staff members stayed in the general population unit with a tenant until 4:45 am when Staff #5 reported she returned to the dementia unit.

During interview on 1-25-11, Staff #1 reported that Staff #5 asked him to come to a tenant's room to take a manual blood pressure so he left the unit unattended for about ten minutes. While the dementia unit was unattended, Staff #1 and Staff #5 assisted a general population tenant to soak his/her hand, called the on-call nurse, gave the tenant medication, took the tenant's blood pressure and assisted the tenant to toilet. Staff #1 stated that since October 2010, he was aware of two or three times when he had left the unit while the he tenant's were sleeping. Staff #1 stated he thought it was appropriate to leave the dementia unit if a tenant in general population is sick and/or staff needed help.

The program policy titled, "Mandatory Safety on Memory Gardens," directed for a minimum of one staff member to be on duty at all times. The nurse, Chief Operating Officer and Director stated the expectation was that staff in the dementia unit was not to leave the unit unattended.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

Dated this 8th day of March, 2011.