IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

April 7, 2011

Ms. Sarah Ingstad, Director
Sunnybrook Assisted Living
3515 Diana Queen Drive
Muscatine, IA 52761

RE: Final Recertification Monitoring Evaluation Report – Sunnybrook Assisted Living, Muscatine, IA

Dear Ms. Ingstad:

Enclosed is the **Final 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 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 **S0288** with effective dates of **October 15, 2010** through **October 14, 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 Recertification Monitoring Evaluation Report

Assisted Living Program:

Sarah Ingstad, Director
Sunnybrook Assisted Living
3515 Diana Queen Drive
Muscatine, IA 52761

Date of Monitoring Visit:

January 31, 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 Recertification Monitoring Evaluation 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 monitoring evaluation was conducted at Sunnybrook Assisted Living on January 31, 2011. 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:	34
Current number of tenants with cognitive disorder:	1
Total Population of GPP:	35

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:	46

***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 16 tenants. The te3nants reported the program was a great place to live with good staff that responded within five minutes to calls. They stated the food was OK but the staff could use more training in serving etiquette. The tenants said there were plenty of activities offered and they were satisfied and would recommend the program to others.

Program History – There have been no substantiated Regulatory Insufficiencies 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, a 90 year old residing in the program's dementia unit (The Gardens), was admitted on 6-6-10 with diagnoses of: Osteoarthritis, Osteopenia, Depression, Hypertension (HTN) and Memory Loss. On 10-1-10, the tenant was staged at a 3 on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.

Tenant #1's clinical record contained a copy of a letter sent to the tenant's physician on 12-9-10. The letter indicated the tenant staged at a 4 on the GDS, indicating moderate cognitive decline, which showed deterioration in cognitive status since 10-1-10. The letter reported program staff believed the tenant no longer had the capacity to make sound medical decisions for him/herself, thereby requesting the physician's agreement of the program's assessment in order to activate the tenant's durable power of attorney.

The tenant's clinical record contained nurse notes related to medication changes on 10-13-10 and 11-22-10 however; both notes indicated the tenant experienced no changes in cognitive, health or functional status. The record lacked a nurse review between 11-22-10 and 12-9-10 despite apparent changes in the tenant's cognitive status.

The tenant's clinical record contained a 90 day nurse review, dated 12-30-10, which indicated the tenant experienced no change in cognitive or functional status however had been having days where he/she preferred to remain in his/her room more often. The nurse indicated a plan to make a referral to the tenant's physician to discuss initiation of medication for depression.

According to the Incident Report, dated 1-4-11, Tenant #1 fell while in the dining room of the Gardens. The tenant complained of soreness on the left side of the body, focusing on the leg/hip area but with no apparent injury. On 1-5-11, staff found the tenant to be very lethargic and difficult to arouse for the day. Program staff sent the tenant to the emergency room via ambulance, where she was admitted to the hospital and remained until 1-10-11.

The tenant returned to the program on 1-10-11 with the new diagnosis of urinary tract infection. The nurse completed a significant change evaluation of the tenant's functional and health status on 1-10-11 however failed to complete an assessment of the tenant's cognitive status.

On 1-31-11 Staff #1, Corporate Marketing/Registered Nurse, reported she had completed the assessments for Tenant #1 on 1-10-11 however had forgotten to complete the cognitive assessment.

Tenant #3, an 89 year old residing in the program's dementia unit (The Gardens), was admitted on 10-7-09 with diagnoses of: Multifarct Dementia, Atrial Fibrillation and Hypertension (HTN). On 10-7-09, the tenant was staged at a 5 on the GDS, which indicated moderate severe cognitive decline.
The nurse completed an annual evaluation of the tenant's functional and health status on 10-6-10 however failed to complete an assessment of the tenant's cognitive status.

On 1-31-11 the Program Manager reported a belief that a cognitive assessment is not required once tenants reach a 4 on the GDS scale, therefore the nurse omitted the cognitive assessment.

Tenant #4, a 90 year old, was admitted 11-10-08 with diagnoses of: History of Cerebral Vascular Accident, Hyperlipidemia, Diabetes, Osteoarthritis, and Peptic Ulcer. On 10-28-10, the tenant was staged at a 4 on the GDS, which indicated moderate cognitive decline. The Nurse's Notes dated 1-3-11 documented the tenant was more confused and upon report to the physician, a urinalysis (UA) was ordered. On 1-4-11, the UA was found to be negative and the program requested consideration for starting a medication for dementia such as Aricept or Namenda. The clinical record lacked evidence of completion of cognitive, functional or health evaluations with the change noted in the tenant's behavior.

- 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 when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Nurse Review

Monitoring Observation: Tenant #1's clinical record contained a copy of a letter sent to the tenant's physician on 12-9-10. The letter indicated the tenant staged at a 4 on the GDS, indicating moderate cognitive decline, which showed deterioration in cognitive status from the previous staging on 10-1-10. The letter reported program staff believed the tenant no longer had the capacity to make sound medical decisions for him/herself, thereby requesting the physician's agreement of the program's assessment in order to activate the tenant's durable power of attorney. The tenant's clinical record contained nurse notes related to medication changes on 10-13-10 and 11-22-10, however both notes indicated the tenant experienced no changes in cognitive, health or functional status. The record lacked a nurse review between 11-22-10 and 12-9-10 despite apparent changes in the tenant's cognitive status.

Tenant # 2, a 79 year old, was admitted 10-14-09 with diagnoses of: Anemia, End Stage Renal Disease, Spinal Stenosis, Chronic Obstructive Pulmonary Disease, HTN, Hyperlipidemia, Osteoarthritis, and Depressive Disorder. The clinical record contained a transcription note from the physician dated 11-22-10 which documented the physician visit concluded the tenant had weight loss. A physician's order received and noted by the nurse on 12-22-10 directed for weekly weights. The clinical record lacked documentation of completion of weights for weeks of 11-22, 11-29, 12-7, 12-20, 12-27-2010, 1-3 or 1-9-2011. The weight documented 11-8-10 was 152 pounds and the weight documented on 1-17-11 was 149 pounds. The clinical record lacked documentation of completion of a nurse review regarding the tenant's weight loss following concerns identified by the physician.

- 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))

Dated this 31st day of March 2011.