IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33101-I

March 31, 2011

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

RE: Final Incident Investigation Report – Sunnybrook of Muscatine, Muscatine, IA

Dear Ms. Ingstad:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of March 28, 2011, 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 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

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

Assisted Living Program: **Incident Intake #: 33101-I**

Sarah Ingstad, Director
Sunnybrook of Muscatine
3515 Diana Queen Drive
Muscatine, Iowa 52761

Date of Incident Investigation:

March 28, 2011

Monitor(s):

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 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 Muscatine on March 28, 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:	32
Current number of tenants with cognitive disorder:	2
Total Population of GPP:	34

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

Total Population of DSP:	9
Total Census of ALP:	43

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

Program History – There have been no substantiated Regulatory Insufficiencies 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 staff found a tenant on the floor in his/her room. The tenant was admitted to the hospital with a diagnosis of intraparenchymal brain hemorrhage with an additional diagnosis of over-anticoagulation. The program reported the tenant experienced two falls in January 2011 without injury. The tenant had a pathological fracture of the hip without known fall on 1-21-11 requiring a partial hip replacement.

- Monitoring Observation: The monitor reviewed the clinical records of three tenants who experienced falls with injury.

  Tenant #3, a 90 year old residing in the memory care unit, was admitted on 6-16-10 with diagnoses of: Osteoarthritis, Osteopenia, Depression, Memory Loss and Hypertension. The tenant was scored at a 5 on the Global Deterioration Scale (GDS) which indicated a moderately severe cognitive decline.

  The tenant's clinical record indicated the tenant complained of an inability to stand without pain on 1-21-11. The tenant had experienced recent falls on 1-4-11 and 1-18-11 resulting in no injury. The tenant had no known fall on 1-21-11. Staff sent the tenant to the emergency room where he/she received the diagnosis of pathological fracture of his/her hip which required a partial hip replacement. The tenant returned to the program following rehabilitation on 2-23-11.

  According to the service plan, dated 2-17-11, tenant required staff assistance for bathing, dressing, grooming, toileting and transferring. The tenant required reminders from staff to use his/her walker and would require assistance with ambulation due to weakness and recent hip repair until the tenant got stronger.

  Coumadin, a blood thinner, was initiated following the hip fracture. Upon discharge from the skilled rehabilitation facility, the tenant's physician ordered a prothrombin time (PT) to be drawn on 2-24-11. A PT is a laboratory test to determine the time taken for the tenant's blood to clot and is monitored while the tenant is taking any blood thinner to determine the medication effectiveness and to assure the blood does not get too thin. The program staff obtained the PT on 2-24-11 which resulted in a 3.3 INR. Normal INR is 0.8 to 1.2. The nurse immediately reported the high results, which indicate over-anticoagulation to the tenant's physician. The physician chose to leave the tenant on the same dose of Coumadin at that time however ordered a second PT to be drawn on 3-1-11.

  According to interviews of multiple staff and review of the program's occupancy agreement, staff routinely performs a physical observation of tenants residing in the memory care unit throughout the night on an hourly basis. On 3-1-11 at approximately 6:30 AM, Staff #1, a universal worker, checked on Tenant #1, finding the tenant in bed sleeping. At approximately 7:00 AM, Staff #1 heard someone yelling "help". Staff #1 found Tenant #1 lying on the floor in his/her room behind a recliner. The tenant reported pain in his/her right hip and rib area and reported hitting his/her head during the fall. The tenant denied a headache at the time of the fall and had no obvious injuries involving bruising or open areas from a head wound.

Staff #1 immediately contacted Staff #2, licensed practical nurse (LPN), reported the fall and tenant reports of pain. Staff #2 directed Staff #1 to call 911 and have tenant transported to the emergency room for medical attention. Staff #1 contacted the tenant's durable power of attorney (DPOA) and the tenant's physician following the tenant's transfer from the program. An incident report was completed according to requirements. At the hospital the tenant was diagnosed with an intraparenchymal brain hemorrhage and a PT INR level of 4.4.

The monitor found no program culpability. The service plan accurately reflected the tenant's needs. Staff routinely performed hourly checks to assure tenant safety. The tenant experienced difficulty remembering to wait for assistance due to cognitive decline. Staff responded appropriately following the tenant's injury. The nurse reported the tenant's PT results to the physician in a timely fashion. The nurse could not recheck the PT on 3-1-11 due to the tenant's fall in the morning with subsequent admission to the hospital.

The monitor reviewed the clinical records of two additional tenants who experienced falls with injury finding no concerns with program culpability.

- Regulatory Insufficiency: None noted.

Dated this 31st day of March 2011.