IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 33815-C
Incident Intake #: 34311-I

July 11, 2011

Angela Beardsley, RN Manager
SunnyBrook Assisted Living
5025 River Valley Road
Ft. Madison, IA 52627

RE: Final Complaint and Incident Investigation Report – SunnyBrook Assisted Living, Ft. Madison, IA

Dear Ms. Beardsley:

Enclosed is the **Final Complaint & Incident Investigation 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 reviewed both your Plan of Correction (POC) and Request for Reconsideration in response to the **Final Complaint & Incident Investigation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiency, DIA accepts your POC.

Based on the information provided in the Request for Reconsideration, DIA denies your request as it relates to Nurse Review. Additional documentation submitted does not support that the program was in compliance with regulations at the time of the on-site.

If you have any questions, 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 Complaint & Incident Investigation Report

Assisted Living Program:

Angela Beardsley, RN Manager
SunnyBrook Assisted Living
5025 River Valley Road
Ft. Madison, IA 52627

Complaint Intake #: 33815-C
Incident Intake #: 34311-I

Date of Investigation:

June 15, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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 Assisted Living on June 15, 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:	30
Current number of tenants with cognitive disorder:	0
Total Population of GPP:	30

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

Total Population of DSP:	12

Total Census of ALP: 42

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

Program History – The program received a regulatory insufficiency in the area of Evaluation during this certification period.

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

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Nurse Review

Complaint Allegation #33815-C: It was alleged a tenant fell and staff did not respond appropriately to the tenant after a fall. It was alleged the tenant was not assessed appropriately after a fall.

- Monitoring Observation: Three tenant files and Event Reports for the last three months were reviewed.

Tenant #2 (the Tenant), an 87 year old, was admitted on 3-23-10 and diagnoses include: Parkinson's Disease, Hypertension (HTN), Seborrheic Dermatitis, Constipation, Dry Eyes, History of Gout, History of Malignant Melanoma Left Back, Lewy Body Disease and Post Prandial Hypotension with Dysrhythmias. 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 and received Hospice services. Event Reports indicated the Tenant had over 10 falls from 4-13-11 to 6-1-11. The service plan reflected a history of falls. Review of the Tenant's file and Event Reports indicated staff responded appropriately to the falls and the Tenant was assessed as needed.

Tenant #3 (the Tenant), an 84 year old, was admitted on 12-16-10 and diagnoses include: Dementia, HTN, History of Rib Fractures, Chronic Obstructive Pulmonary Disease and Hyperlipidemia. The Tenant was staged at four on the GDS, which indicated moderate cognitive decline. The Tenant resided in the dementia unit. According to an Event Report dated 4-11-11 at 3:00 a.m. the Tenant showed a staff member that he/she had a lighter and refused to give it to the staff member. The Tenant dropped it on the floor and the staff member locked up the lighter. The Tenant retaliated and lost his/her balance. The tenant was lowered to the floor, according to the report. The Tenant refused assistance to get up and only complained of back pain from lying on the floor. According to the report, the Tenant refused all vitals. Nurse's Notes dated 4-13-11 indicated the Nurse received a telephone call from staff regarding the events that occurred on night shift. The Tenant was taken to the emergency room (ER) for evaluation. Family was aware of the Tenant's outburst, refusal to get off the floor and complaints of ankle pain. The service plan indicated the Tenant's cigarettes were locked for his/her safety. The Tenant preferred to have staff assist him/her to smoke and staff accompanied the tenant if he/she felt the need to smoke. The Tenant signed the service plan.

The Tenant was interviewed and reported staff treated him/her well. The Tenant said he/she was pushed down in another home which was a branch of the Program. A man told him/her that he needed his/her cigarette lighter. He laid the Tenant down on the ground and blew cold air on the tenant. The Tenant wanted to call the police and the hospital. He offered to pick the Tenant up and he/she refused because the Tenant had previously had trouble with his/her back. The Tenant did not want him to pick the Tenant up. The Tenant stated he took the lighter out of his/her pocket and he laid the Tenant on the floor. He did not touch the Tenant. He/she went to the hospital and got a brace on his/her leg.

Staff #2 worked third shift that night in the dementia unit and provided a written statement. He indicated the Tenant pulled out a lighter that he was not aware of and the Tenant said he/she was holding it for a friend who was picking him/her up for surgery. He tried to convince the Tenant to give him the lighter to lock up and the Tenant refused. The Tenant pulled the lighter out of his/her pocket and went to put it back in his/her pocket and dropped the lighter. The Tenant became mad and started walking with a faster pace. The Tenant went to the doors at the dining room and set off the alarm. The Tenant walked toward the front doors and he got in front of the doors to prevent him/her from setting them off. The Tenant tried pushing him out of the way and gave up and started walking to the living room when the Tenant started to lose balance. Staff #2 was walking behind the Tenant and put his hands on the Tenant's waist to correct his/her balance. Staff #2 lowered the Tenant to the floor and then the Tenant laid back. Within minutes, the Tenant started telling Staff #2 that he threw the Tenant down. Staff #2 called Staff #3 to assist and she offered to help the Tenant up and the Tenant refused. Staff #2 called and left a voicemail for the Nurse. He let the Tenant calm down and asked if the Tenant wanted to get up every one to two minutes. The Tenant refused and Staff #2 gave him/her a pillow and something to cover up with. The Tenant refused those items and threw them beside him/her. Staff #2 spoke with the Nurse and she agreed to leave the Tenant alone to mellow out. Staff #2 checked on the Tenant and continued to offer assistance to get up. The Tenant refused and tried to kick Staff #2. He said the Tenant acted like he/she had a phone in his/her hand and was talking to a friend. When first shift came on Staff #2 told them what had happened. Staff #2's interview and written statement were similar and consistent. He reported in an interview he attempted to get the Tenant up off the floor over 20 times. He also stated that he did not push the Tenant; however, the Teant pushed him and he did not reach into the Tenant's pocket. He stated the Tenant did not request to go out to the hospital or to be seen by anyone.

Staff #3 worked third shift that night in the general population and provided a written statement. She was called by Staff #2 to assist with the Tenant. The Tenant was on the floor and was yelling and screaming and she tried to calm the Tenant down but nothing worked. The Tenant said Staff #2 pushed him/her down and he/she wanted her to call the police and wanted to go to the hospital. She said the Tenant said he/she was in pain. She was interviewed and could not recall if the Tenant requested to be sent to the hospital. She also could not recall if the Tenant had been in any pain.

Staff #4 worked first shift that morning and provided a written statement. She walked into the dementia unit and saw the Tenant lying on the ground. The Tenant stated Staff #2 pushed him/her down. She then asked the Tenant if he/she wanted help getting up and the Tenant refused and said he/she was not getting up until a professional told him/her it was okay because of back surgery. After awhile, another staff member attempted to get the Tenant off of the ground. At that time, the Tenant kept touching his/her ankle and when staff looked at his/her ankle they noticed a big swollen bump. Staff called the Nurse and it was decided to send the Tenant to the ER. The Tenant later returned with a sprained ankle. She indicated the Tenant told her he/she had been laying there since 3:45 a.m. and he/she had told Staff #2 many times to call the police so they could tell the Tenant if he/she could get up.

The Nurse stated she received a phone call from Staff #2 and he stated the Tenant had fallen. Over the phone the Nurse heard the Tenant yelling for him to get away from him/her. The Nurse was told the Tenant denied pain and did not want anyone around him/her. The Nurse talked to the Tenant on the phone and he/she recognized it was the Nurse. The Tenant told the Nurse that Staff #2 had pushed him/her and that he/she was not hurt. The Tenant was very upset and did not want medical attention. The Nurse stated Staff #3 needed to become involved with the situation. She received a telephone call from first shift staff and they reported the Tenant complained of ankle pain. She called the Tenant's family. The Tenant went to the ER by ambulance and returned with a fracture.

According to a Physician Order Sheet dated 4-11-11, the Tenant sustained a left ankle non-displaced medial malleolar fracture. The Tenant needed to wear a boot at all times except for showers. The Tenant was non-weight bearing.

According to Major Injury Determination Form, a physician indicated the Tenant did not sustain a major injury.

The Program was a smoke-free community, which included all apartments. Tenants who wished to smoke were to go outside the building to an area where there was a smoker's receptacle.

Tenant rights for the Program included the right to refuse services.

- Regulatory Insufficiency: If a tenant does not receive personal or health related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 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))

B. Other

Incident Allegation #34311-I: The Program reported staff heard a loud noise coming from a tenant's apartment and the tenant was found lying on the floor with a walker on top of the tenant. The tenant told staff he/she got up to get a cup of coffee and was not wearing the emergency pendant. The tenant complained of left hip pain, lower back and neck pain. The tenant told the staff and the Nurse via telephone that he/she wanted to go to the hospital. Staff called 911 and the Nurse called the tenant's family.

- Monitoring Observation: Tenant # 1 (The Tenant), a 91 year old, was admitted on 10-13-09 and diagnoses include: Gastric Esophageal Reflux Disease, Chronic Anemia, HTN, History of Leg Fracture, Congestive Heart Failure, History of Knee Replacement, History of Urinary Tract Infection, Osteoporosis and History of Vertebral Fracture of T-12. The Tenant sustained a non-displaced left femoral neck fracture and died on 5-29-11. The service plan indicated the Tenant requested assistance of staff to ambulate him/her to meals using a walker as far as the Tenant was able to ambulate. The Tenant requested staff follow him/her with a wheelchair to

allow the Tenant to sit and be pushed the remainder of the way. The Tenant liked to use the wheelchair for long distances and liked to have staff walk with him/her twice a day in the hall.

According to an Event Report, on 5-28-11 at 6:13 a.m. staff heard a loud noise and entered the Tenant's room and found him/her on the floor with a walker on top of the Tenant. The Tenant was yelling for help. The Tenant stated he/she had gotten up to get a cup of coffee. The Tenant complained of left hip pain, lower back pain and neck pain. A phone call was made to the nurse, the family, and the ambulance. Staff #1 held the Tenant's head still until the emergency medical technicians arrived.

Staff #1 stated she had been in the Tenant's room at 5:30 a.m. and the Tenant was asleep. At approximately 6:00 a.m. she heard a thud and ran to the Tenant's room, to find the Tenant on the floor with a walker on top of him/her. She asked the Tenant if he/she wanted to go to the hospital and the Tenant did not want to go to the hospital. Staff #1 called the Nurse and then attempted to assist the Tenant up. The Tenant expressed pain in the left hip, a tingling feeling in the back and neck so Staff #1 kept the Tenant still and called 911.

The Nurse stated Staff #1 called her between 6:10 a.m. and 6:15 a.m. Staff #1 stated she had heard something fall, followed by someone yelling. Staff # 1 went to the Tenant's apartment and found the Tenant on the floor. The Nurse asked where the pain was located and the Tenant stated it was severe and he/she wanted to go to the hospital. The Nurse contacted the Tenant's family member who planned to contact another family member to meet the Tenant at the hospital. At approximately 10:00 a.m., the hospital wanted to discharge the Tenant but due to being unable to walk and continuing to complain of pain, the Tenant was kept at the hospital. At approximately 12:00 p.m. or 1:00 p.m. an X-Ray was taken and the Tenant was scheduled to be evaluated by an orthopedic physician. The Nurse called the hospital several times for updates about the Tenant. The Tenant's family member called the Nurse to state the Tenant needed surgery or the Tenant would die or be bedridden. Due to lab results, the surgery was delayed and the Tenant died the following day.

Staff #1 and the Nurse reported the incident was handled appropriately and tenants received good care.

On 5-31-11, the Tenant's physician completed a Major Injury Determination Form indicating the Tenant sustained a major injury.

The Program reported the incident to the Department appropriately. An incident report was completed related to the incident.

- Regulatory Insufficiency: None noted.

Dated this 8th day of July, 2011.