IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 37499-I

February 17, 2012

Ms. Lisa Hanson, Nurse Manager
SunnyBrook of Mt. Pleasant Assisted Living
1406 East Linden Drive
Mt. Pleasant, IA 52641

RE: Final Complaint/Incident Investigation Report, SunnyBrook of Mt. Pleasant Assisted Living, Mt. Pleasant, Iowa

Dear Ms. Hanson:

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 the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, 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 Investigation Report

Assisted Living Program:

Complaint/Incident Intake #: 37499 -I

Lisa Hanson, Nurse Manager
SunnyBrook of Mt. Pleasant Assisted Living
1406 East Linden Drive
Mt. Pleasant, IA 52641

Date of Complaint/Incident Investigation:

January 25, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	32
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	32
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	6
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	43

Program History – There were regulatory insufficiencies cited during this certification period in the area of medications.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Staffing

During the course of the monitoring visit, the following information was obtained:

- Monitoring Observation: Four tenant files were reviewed. Tenant #1, a 91 year old, was admitted on 7-26-10 and diagnoses include Hypertension, Glaucoma, Hypothyroidism, Congestive Heart Failure, Left Eye Macular Degeneration, Gastro Esophageal Reflux Disease, Arthritis and a history of Urinary Tract Infections. Tenant #1 was staged at a four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #1 had resided in the dementia unit. Tenant #1 died on 12-25-11.

  Tenant #1's service plan dated 7-25-11 indicated he/she ambulated with a wheeled walker independently. The plan also indicated Tenant #1 did not like to ambulate long distances and would request to be pushed on his/her seated walker. Tenant #1 occasionally had delusional/hallucination episodes that could last for one to four or more days. During those times Tenant #1 would often state he/she could not bear weight or ambulate. During the episodes staff would encourage Tenant #1 to stand with the walker and ambulate and if he/she was not able then the wheelchair (w/c) was used to transport him/her. Staff would use an assist of one for Tenant #1's ambulation during those times.

The service plan indicated Tenant #1 was independent with assistive device (walker), was an assist of one to transfer and used a w/c for longer distances.

According to an Event Report dated 12-13-11 at 6:00 pm, Tenant #1 was sitting on the walker and Staff #1 was pushing him/her when the wheel got caught where the carpet ended and tile began. Staff #1 attempted to stop the walker from falling but Staff #1 fell on the floor. Tenant #1 landed on the floor on top of Staff #1 while remaining seated in the walker. Tenant #1's back was on the floor. Tenant #1 complained of back and neck/shoulder pain but stated "just get me up, I'm okay."

Tenant #1 used the wheeled walker every day. Family members pushed Tenant #1 on the wheeled walker when they took Tenant #1 out of the Program. Staff #1 stated staff members would push Tenant #1 on the wheeled walker when Tenant #1 went long distances. Staff #1 was not aware of any other incidents involving Tenant #1's wheeled walker. Staff #1 stated the expectation for using wheeled walkers was tenants could push themselves on the walker and they could use it for transport. Staff #1 stated she was aware of how to use a wheeled walker. Staff #1 stated she had been delegated on the use of a wheeled walker and that it could be used to push someone on it like a w/c. Staff #1 stated she would offer Tenant #1 the choice of using the wheeled walker or the w/c for transport.

Nurse's/Care Notes on 12-20-11 at 8:40 am indicated Tenant #1's family member was pushing Tenant #1 on the seated walker to the car. The Nurse Manager told the family member she wished the family member would not do that as it was unsafe. The family member took Tenant #1 out of the Program to the family member's home.

Operating instructions for several manufacturers of four wheeled walkers with brakes and a seat were researched on the internet. According to manufacturers' assembly, installation and operating instructions for a four wheeled walker with brakes and a seat, it was not to be used as a w/c or transport device. It was not intended to be propelled while seated. The brakes must be in the locked position before using the seat. The backrest was not designed to support the body weight of the user. It also indicated not to exceed the body weight as listed on the product. One manufacturer listed the weight capacity at 250 pounds. According to the December 2011 Medication Administration Record, Tenant #1's weight was 140 pounds.

Staff #1, #2 and #3 had nurse delegations for ambulation with a walker. The delegation addressed both standard and wheeled walkers. The wheeled walker delegation indicated to explain the procedure to the tenant, explained a wheeled walker had wheels on the front legs and rubber tips on the back legs. The tenant pushed the walker ahead about six to eight inches and then walked up to it. The rubber tips on the back legs prevented the walker from moving while tenant was walking. The delegations were signed by the staff members and the Nurse Manager.

The service plan indicated Tenant #1 would request to be pushed on his/her seated walker. This was listed on the service plan despite, manufacturers' instructions for the wheeled walker with brakes and a seat not to be used as a w/c or transportation device. Staff was not trained appropriately to fully meet tenants' identified needs regarding ambulation with a four wheeled walker.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9 (1))

B. Other

Complaint/Incident Allegation: The Program reported a staff member was transporting a tenant who was seated on a wheeled walker. The walker got caught on the carpet, which caused the tenant, walker and staff member to fall. The Program reported the tenant did not start complaining of discomfort or pain until one week later, after having been home with family and having a chiropractic treatment. The tenant was transferred to a hospital, diagnosed with a fractured right hip, underwent surgical repair and died two days later.

- Monitoring Observation: Four tenant files were reviewed. Tenant #1's file was reviewed.

  According to an Event Report dated 12-13-11 at 6:00 pm, Tenant #1 was sitting on the walker and Staff #1 was pushing him/her when the wheel got caught where the carpet ended and tile began. Staff #1 attempted to stop the walker from falling but Staff #1 fell on the floor. Tenant #1 landed on the floor on top of Staff #1 and remained seated in the walker. Tenant #1's back was on the floor. Tenant #1 complained of back and neck/shoulder pain but stated "just get me up, I'm okay."

  Nurse's/Care Notes dated 12-13-11 at 6:05 pm, indicated the Nurse Manager received a call from staff stating a Universal Worker (UW) was bringing Tenant #1 to the front to go on a van ride. Tenant #1 was sitting on the seat of his/her wheeled walker and was pushed by a UW until the carpet ended and tile began, the walker wheel caught which caused the walker to tip. A UW tried to correct the fall but both the UW and Tenant #1 fell and Tenant #1 remained seated on the walker with his/her head lying flat on the ground. Tenant #1 stated he/she was okay and to get him/her up. The Nurse Manager instructed staff to get Tenant #1 up with the assistance of two staff members. Tenant #1 complained of neck and shoulder discomfort but denied hurting anywhere else. The Nurse Manager instructed staff to use a w/c to transport Tenant #1 for long distances. Staff voiced understanding.

  Staff #1 stated she was getting Tenant #1 ready to go see Christmas lights and was pushing Tenant #1 down the hall while Tenant #1 was seated on the wheeled walker facing her. At the point where the tile started and the carpet ended, one of the wheels got caught and the walker started to go down. She put her left arm behind Tenant #1's head to protect the head and Tenant #1 grabbed her jacket and both of them fell on the floor to the left of the walker. Staff #1 stated Tenant #1 never came off the seat of the walker and did not hit his/her head. Staff #1 stated about four or five other staff helped get Tenant #1 and Staff #1 up off the floor. Tenant #1 did not complain of pain after the incident. The Nurse Manager was called who instructed staff to monitor Tenant #1 for pain. Tenant #1 used the wheeled walker every day. Family members pushed Tenant #1 on the wheeled walker when they took Tenant #1 out of the Program. Staff #1 stated staff members would push Tenant #1 on the wheeled walked when Tenant #1 went long distances. Staff #1 was not aware of any other incidents involving Tenant #1's wheeled walker.

Staff #1 stated the expectation for using wheeled walkers was tenants could push themselves on the walker and they could use it for transport. Staff #1 stated she was aware of how to use a wheeled walker. Staff #1 stated she had been delegated on the use of a wheeled walker and that it could be used to push someone on it like a w/c. Staff #1 stated during the month of December, Tenant #1 complained of knee pain. Tenant #1 had gone out with a family member and when Tenant #1 returned, indicated he/she had pulled a muscle at the family member's house. The family member had also taken Tenant #1 to the chiropractor. Staff #1 stated Tenant #1 was able to ambulate after the incident. Staff #1 stated she would offer Tenant #1 the choice of using the wheeled walker or the w/c for transport.

Staff #1 showed the monitors the place on the floor where the incident occurred at the point where the hallway carpet ended and tile floor started. No defects in the carpet or tile were observed.

Nurse's/Care Notes dated 12-14-11 indicated Tenant #1 denied discomfort and had been transferring and ambulating with the wheeled walker independently. Nurse's/Care Notes dated 12-15-11 indicated Tenant #1 was doing well, denied discomfort and remained independent with transfers and ambulation.

On 12-20-11 at 8:40 am, a family member was pushing Tenant #1 on the seated walker from the Program to the car. The Nurse Manager told a family member she wished he/she would not do that as it is unsafe. A family member took Tenant #1 out of the Program to a family member's home. On 12-20-11 at 2:30 pm, a family member returned with Tenant #1 and asked to speak to the Nurse Manager. A family member reported later in the morning, Tenant #1 suddenly complained of right groin discomfort and did not want to bear weight on right lower extremity. A family member had difficulty getting Tenant #1 into the van, so a family member took Tenant #1 to the chiropractor for an adjustment. At 2:50 pm, the Nurse Manager asked Staff #3 about Tenant #1's morning. Staff #3 reported Tenant #1 followed his/her normal routine. When Staff #3 assisted Tenant #1 with his/her shower, Tenant #1 complained of knee discomfort which was a daily complaint. After the shower and getting dressed, Tenant #1 ambulated independently with the wheeled walker to the dining room. At 4:30 pm, the Nurse Manager checked on Tenant #1 and he/she was sitting up on the side of the bed. When asked what Tenant #1 was doing, he/she responded, "I'm looking for my shoes, I'm ready to get up." The Nurse Manager assisted with the shoes, administered the scheduled dose of Tylenol and Tenant #1 got up from the bed independently. Tenant #1 ambulated with the wheeled walker to the dining room independently.

On 12-21-11, a UW reported Tenant #1 was ambulating independently but noticed he/she would favor the right lower extremity at times. On 12-22-11 at 11:10 am, Tenant #1's family member asked to see the Nurse Manager. When the Nurse Manager arrived at Tenant #1's apartment, a family member stated Tenant #1 was hurting. The Nurse Manager sat down beside Tenant #1 and asked where he/she hurt. Tenant #1 stated, "Oh, I don't know, I hurt all over." A discussion was held about the possibility of Tenant #1's discomfort being due to the chiropractic adjustment. A family member and his/her spouse agreed the adjustment might have been the reason. Tenant #1 was given Tylenol to help with the discomfort.

At 12:30 pm, a UW reported after Tenant #1's family member left, Tenant #1 started hollering out and when a UW went to the apartment, Tenant #1 moaned, so a UW helped Tenant #1 lie down. Once Tenant #1 laid down, he/she calmed down and was fine. A UW reported Tenant #1 got up independently that morning, dressed, made the bed and came out to breakfast. At 6:30 pm, the Nurse Manager received a call from a UW stating a family member had called, asked about Tenant #1 and a UW told a family member Tenant #1 complained of pain. A family member asked if he/she should take Tenant #1 to be seen by a doctor. A UW notified the Nurse Manager, who contacted a family member and reported staff had just laid Tenant #1 down and wanted to see if he/she calmed down. If Tenant #1 did not calm down and continued to have complaints of pain in the next 45 minutes a family member would be called. The Nurse Manager received a phone call at 7:10 pm from a UW stating Tenant #1 continued to holler out so a family member was contacted and was on the way to the Program. At 8:00 pm, the Nurse Manager received a phone call from a UW reporting a family member took Tenant #1 via private car to a local hospital emergency department.

On 12-23-11 at 12:50 am, the Nurse Manager received a call from a UW who stated one of Tenant #1's family members was at the Program to pick up personal items and Tenant #1 was being transferred to a regional hospital due to a hip fracture. At 9:00 am, the Nurse Manager contacted a family member who reported Tenant #1 had a crack on the top of the right hip and was waiting for the cardiologist to clear Tenant #1 for surgery. A family member stated a rod was going to be placed in the hip. At 5:00 pm, the Nurse Manager received a call from a family member who stated the surgery went well, the ball of the hip was replaced and Tenant #1 was back in his/her room and resting comfortably.

On 12-25-11 at 10:00 am, the Nurse Manager received a call from a UW who reported a family member called stating Tenant #1 had died around 3:00 am. On 12-30-11, the family removed personal items from Tenant #1's apartment and returned apartment keys and a pendant.

Staff #1, #2, #3 and the Nurse Manager indicated there was enough staff to meet the needs of the tenants. Staff #1, #2 and #3 indicated there were no tenants that exceeded level of care. The Nurse Manager indicated there was one tenant moving out on 1-26-12, and there were no tenants that exceeded level of care.

Tenant #1 ambulated independently with the use of a wheeled walker. Tenant #1 suffered a fall on 12-13-11 and complained of discomfort in the back, neck and shoulder area, however, Tenant #1 continued to go about his/her normal routine. One week later, Tenant #1 was out of the Program and went to a family member's home before complaining of right lower extremity discomfort. Later that same day, Tenant #1 had a chiropractic adjustment. During the investigation it could not be determined how or when the fracture occurred. An incident report was completed related to the fall on 12-13-11 and the Department was notified.

Regulatory Insufficiency: None noted.