IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 39938-I

August 22, 2012

Ms. Jessica Umthun, Manager
Sunnybrook of Fort Madison
5025 River Valley Road
Fort Madison, IA 52627

RE: Final Complaint/Incident Investigation Report – Sunnybrook of Fort Madison, Fort Madison, IA

Dear Ms. Umthun:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of August 2, 2012, 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 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

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: **Complaint/Incident Intake #:** 39938-I

Jessica Umthun, Manager
SunnyBrook of Fort Madison
5025 River Valley Road
Fort Madison, IA 52627

Date of Complaint/Incident Investigation:

August 2, 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:	31
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	32
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	10
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	42

Program History – The program received regulatory insufficiencies in the areas of: Medications, Service Plans and Dementia Specific education during the April 17 and 18, 2012 Recertification and Incident (38711-I) Investigation.

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

A. Service Plans

Complaint/Incident Allegation: The Program reported a tenant became agitated, went to swing a cane at a staff and the staff stepped away to avoid being hit. The tenant lost his/her balance, fell and fractured a hip.

- Monitoring Observation: Three tenant files were reviewed. Tenants #1, #2 and #3 had falls. Tenant #1 had a fall and fractured a hip.

  Tenant #1, an 80 year old, was admitted on 12-26-11 and diagnoses include: Alzheimer's Disease, Diabetes Mellitus Type II, Gait Abnormalities, Hypercholesteremia, Hypertension, Memory Loss, Transient Ischemic Attack, Cataract Surgery, Coronary Artery Disease and Quadruple Bypass. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit and was out of the Program at a skilled nursing facility (SNF) at the time of the investigation.

  Cognitive, health and functional evaluations were completed on 6-8-12. A service plan was updated on 6-8-12. The service plan reflected physical therapy was coming in for strengthening and gait. The service plan also reflected Tenant #1 potentially

could be a fall risk due to an unsteady gait. A cane was used for stability. The service plan also reflected Celexa was ordered for aggression and it had helped but Tenant #1 had Xanax ordered if needed. The service plan identified Tenant #1's behaviors and provided interventions including to let Tenant #1 vent, apologize and walk away and let Tenant #1 cool down. If things got out of hand Tenant #1 usually benefited from talking with the Health Care Coordinator and Manager. Sometimes Tenant #1 just needed to talk and get things off Tenant #1's shoulders, family was involved and was available if Tenant #1 got too upset. Xanax was for ordered for aggression as needed and if Tenant #1 started to dwell on something that upset Tenant #1 to give Xanax to prevent it from escalating. Tenant #1 had one other fall on 6-14-12 and there was no physical injury or complaints of pain, according to Nurse's Notes.

According to an Event Report, on 7-9-12 at 7:30 a.m., Tenant #1 entered the dementia unit dining area very upset about the "system" in Tenant #1's apartment. Tenant #1 proceeded toward the secured doors and demanded to "see the boss." Tenant #1 beat on the door with his/her hand and set off the alarm three to four times while Tenant #1's voice was raised and demanded Staff #1 open the doors. Staff #1 did not open the doors and Tenant #1 made verbal threats to Staff #1. Tenant #1 stepped forward, drew the cane upward and convinced Staff #1 that Tenant #1 intended to carry out the threats to injure Staff #1. Tenant #1 swung the cane toward Staff #1's head, Staff #1 stepped away as Tenant #1 swung the cane where Staff #1 had been. Tenant #1 appeared to lose his/her balance and fell to the floor. Tenant #1 refused any assistance and continued making verbal threats to Staff #1 as Tenant #1 walked to Tenant #1's apartment. Tenant #1 refused vital signs. The Health Care Coordinator and Tenant #1's family were notified.

According to Nurse's Notes, on 7-9-12 staff called and reported Tenant #1 was upset and attempted to hit a staff with a cane and lost his/her balance and fell to the floor. The staff stepped out of the way of being hit with the cane. Staff wanted to assist Tenant #1 off the floor but Tenant #1 refused any assistance and remained hostile towards staff. Tenant #1 ambulated independently with a cane back to the hallway. Tenant #1 did not have any complaints of pain at that time. When other staff checked on Tenant #1 after Tenant #1 was in the apartment, Tenant #1 complained of right hip pain. Staff contacted the Health Care Coordinator. Family was notified immediately and an ambulance was contacted to transport Tenant #1 to the hospital for evaluation. Tenant #1 rested in bed awaiting arrival of the ambulance and was transported to the hospital. Tenant #1 was admitted to the hospital for diagnoses of right non-displaced femoral head fracture. Surgery was scheduled for 7-10-12. Nurse's Notes dated 7-18-12 indicated Tenant #1 was evaluated for return to the Program. Tenant #1 was an increased risk for falls at that time. A decision was made for Tenant #1 to go to a SNF for further rehabilitation. At the time of the investigation, Tenant #1 remained at a SNF.

Staff #1 said Tenant #1 came to the kitchen area and demanded to go up front, wanted to talk to the boss and started hitting the door. Staff #1 was concerned Tenant # 1 would get hurt. Staff #1 talked to Tenant #1, tried to redirect Tenant #1 and Tenant #1 demanded the door be opened. Tenant #1 was saying things to Staff #1 and Staff #1 kept a three foot distance. Tenant #1 spun with the cane, Staff #1 moved to the right, Tenant #1 lost his/her balance, ran into the wall and rolled down. Staff #1

offered assistance and Tenant #1 refused. Tenant #1 got up, walked using the cane to Tenant #1's apartment. Tenant #1 walked with the same gait back to the apartment. Staff #2 came back and took vitals, the Health Care Coordinator came in, an ambulance was called and Tenant #1 was taken out. Staff #1 said he tried interventions with Tenant #1 three times during the incident.

Staff #2 said she came in around 7:30 a.m. or 8:00 a.m. and stopped by the dementia unit right after the incident occurred. She said Tenant #1 was trying to lie down and complained of hip pain. She advised staff to call the Health Care Coordinator. Tenant #1 was transferred to the hospital by ambulance.

The Health Care Coordinator stated she received a telephone call and staff said Tenant #1 had an outburst and had wanted to talk to her or the Manager. Tenant #1 tried to hit Staff #1, Staff #1 moved out of the way, Tenant #1 hit the wall, was still trying to hit with the cane and gradually rolled to the floor. Tenant #1 refused assistance, got up independently and went to Tenant #1's apartment. Tenant #1 showed no signs of injury and crying was normal for Tenant #1 after an outburst. Tenant #1 was lying in bed, crying and told Staff #2 Tenant #1's hip hurt. Staff #2 called the Health Care Coordinator and the family and an ambulance was called. Tenant #1 was transferred to the hospital and was admitted for a right hip fracture.

According to the EMS Report, the ambulance was dispatched at 7:46 a.m. and arrived at 7:52 a.m. No trauma or obvious deformity was noted. The pain did not radiate and the pain was rated at a five with movement or weight bearing. Vitals were obtained.

Staff #1 demonstrated the incident for the monitors. Staff #1 demonstrated Tenant #1 was at the door pivoted with the cane up and Tenant #1 hit wood railing, wobbled and rolled down. Tenant #1 got up without staff assistance.

Tenant #1 ambulated to Tenant #1's apartment after the incident without staff assistance. It was estimated the distance from the doors where the incident occurred to the apartment was approximately 35 yards.

Staff #1, #2, the Health Care Coordinator and the Manager said there was enough staff to meet the needs of the tenants. Staff #1, #2, the Health Care Coordinator and the Manager did not identify any tenants that exceeded the appropriate level of care. The Manager said Staff #1 had additional education as follow up after the incident.

The Program reported the incident to the Department and an Event Report was completed.

Tenant #1's service plan identified various interventions related to Tenant #1's behaviors. Although attempts were made to redirect Tenant #1, there were interventions listed on the service plan that were not utilized in an attempt to redirect Tenant #1 during the incident. While a deviation from requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.