IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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DEMAND LETTER

Complaint Intake #: 46313-M

February 4, 2014

Michelle Sides, Manager
Sunnybrook of Muscatine
3515 Diana Queen Drive
Muscatine, IA 52761

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - SUNNYBROOK OF MUSCATINE
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Sides:

I. Final Complaint/Incident Investigation Report – Sunnybrook of Muscatine, Muscatine, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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, following an investigation by DIA on **December 10 - 18, 2013.** The Report notes Regulatory Insufficiencies in the area(s) of: Program Reporting to Department and Policies and Procedures.

Sunnybrook of Muscatine ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.17(1)(b), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Program Reporting to Department.

The determination of a **$500 civil penalty** is based upon repeated Regulatory Insufficiencies in the area(s) of: Program Reporting to Department. As the enclosed Report details, Program failed on three separate occasions to report alleged abuse or reportable incidents. This investigation resulted in missing medications for three tenants.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.17(5). If you do

not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Jim Berkley** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **three hundred twenty five dollars ($325)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

IV. *Conclusion*

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Jim Berkley, at 515/281-4116 or **James.Berkley@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 46313-M

Michelle Sides, Manager
Sunnybrook of Muscatine
3515 Diana Queen Drive
Muscatine, IA 52761

Date of Complaint/Incident Investigation:

December 10 to December 18, 2013

Monitor(s):

Stephanie Cummins, MA

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:	43
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	43

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	19

TOTAL census of Assisted Living Program	62

Program History – The program received regulatory insufficiencies in the areas of Staffing, Reporting to the Department and Tenant Documents during this certification period.

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

A. Program Reporting to the Department

Complaint/Incident Allegation: The Program reported a tenant who self-administered medications was missing 30 Hydrocodone pills.

- Monitoring Observation: Tenant #1, a 67 year old was admitted on 5-3-13 and diagnoses included: Cerebral Vascular Accident (CVA) with Left Side Weakness, Cataracts, Arterial Disease, History of Bowel Obstruction with Surgery, Bronchiectasis and Interconnective Tissue Disease. Tenant #1 scored a value on the cognitive evaluation which indicated normal mental functioning. The service plan reflected Tenant #1 was independent with medication administration.

  According to a Resident Missing Item Report Form, on 11-1-13 Tenant #1 reported 30 Hydrocodone missing. It was discovered missing on 10-31-13 (p.m.).

  According to the Manager's Notes, on 11-1-13 at 9:00 a.m. Tenant #1 approached her with the suspicion that 30 Hydrocodone pills were allegedly stolen. Tenant #1 was out of the apartment on 10-30-13 from 7:45 a.m. to 5:00 p.m. and was in and out of the apartment on 10-31-13. The notes indicated Tenant #1 was very meticulous and cognitive skills were sharp. Some staff was interviewed in groups using a questionnaire. A private lock was installed on the cabinet door and Tenant #1 and the Manager had the keys.

On 11-1-13 at 3:45 p.m. the Manager, the Healthcare Coordinator and the Dementia Coordinator went to Tenant #1's apartment to look for medications and observe the scene. On 11-1-13 at 7:00 p.m. the incident was reported to the Department. On 11-2-13 the police was notified. On 11-4-13 staff interviews continued. On 11-4-13 the police came to the Program and obtained a statement from Tenant #1. On 11-12-13 it was announced at the Coordinator standup (meeting) it was still under investigation and if anyone had information or saw suspicious behavior to contact the Manager. On 11-15-13 Staff #1 and Staff #2 reported alleged concerns regarding Staff #3 and Tenant #2 and Tenant #3's narcotic medication.

Tenant #2, an 86 year old, was admitted on 8-14-13 and diagnoses included: Hypertension, History of CVA and Hip Replacements. Tenant #2 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline. The service plan reflected Tenant #2 received staff assistance with medication administration. The medications were locked in a cupboard or drawer in Tenant #2's apartment.

Tenant #3, a 93 year old, was admitted on 5-12-12 and diagnoses included: Transient Ischemic Attack, Cardiac Dysrhythmia, History of Urinary Tract Infection, Gastro Esophageal Reflux Disease, Urge Incontinence, Total Knee Replacement, Bone Grafts, Pacemaker, Insomnia, Osteoporosis, Depression, Anxiety, Arthritis, Psoriasis and Hard of Hearing. Tenant #3 scored a value on the cognitive evaluation which indicated normal mental functioning. The service plan reflected Tenant #3 received staff assistance with medication administration. The medications were locked in a cupboard or drawer in Tenant #3's apartment.

According to the Manager's notes, Staff #1 reported Staff #3 did not call her to administer as needed Hydrocodone in particular to Tenant #2. Staff #1 reported when Tenant #2's pendant rang Staff #3 took care of Tenant #2's call even when it was not the hallway Staff #3 was responsible for. Staff #1 reported she had never been called to assist Staff #3 with Tenant #2's as needed medication pass. Tenant #2's narcotic sheets were pulled and it was discovered there were several of Staff #1's initials on the sheets that would have been as needed (medication) which required two staff initials. Staff #1 looked at the dates, times and confirmed the as needed passes on the sheets did not contain Staff #1's handwriting of the initials and someone else had written them. Staff #1's initals would have been present at the 3:00 p.m. times as it was the narcotic count time and Staff #1 was responsible for counting and signing off and those times would include Staff #1's actual initials. Staff #1 reported she witnessed Staff #3 switching medications while administering medications to Tenant #3 on 11-13-13. Staff #1 reported she saw Staff #3 with a medication in one of Staff #3's hands and then punched out Tenant #3's Hydrocodone from the bubble pack with the other hand. Staff #1 reported she saw Staff #3 put the Hydrocodone in Staff #3's pocket and then give Tenant #3 the medication held in the other hand. Staff #1 reported she could see the medication pass transaction.

According to the Manager's notes, Staff #2 confirmed she rarely helped administer as needed Hydrocodone to Tenant #2. Staff #2 reported that on 11-14-13 Staff #3 told Staff #2 that Staff #3 initialed an as needed narcotic dose for Staff #2 when Staff #2 was not present during the administration of the medication. According to Staff #2's written statement, Staff #2 noticed several of her initials that she did not sign.

According to an in-service document regarding medication administration, from 7-18-13 forward the administration of an as needed narcotic required two staff. Both staff would count together and document the amount. The only exception was third shift up front. According to a mandatory meeting document dated 12-10-13, two staff was to be present when administering as needed narcotics. Both staff was required to sign or initial the narcotic inventory sheet. As of 12-10-13 third shift needed to call the nurse for all as needed narcotics to get permission to administer. The narcotic sheet would be placed on the registered nurses (RN) desk so the RN could sign off as the second person the next day.

The Program reported suspected theft of Tenant #1's Hydrocodone on 11-1-13 within the required timeframe to report. On 11-15-13 additional allegations were provided regarding Tenant #2 and Tenant #3 and narcotic medication. The allegations included switching of Hydrocodone and falsification of narcotic records. The Program did not report to the Department the additional alleged victims of alleged dependent adult abuse.

- Regulatory Insufficiency: If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours. (Iowa Code 235E.2(3a))

B. Policies and Procedures

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1's file was reviewed. The service plan reflected Tenant #1 was independent with medication administration.

  According to a Resident Missing Item Report Form, on 11-1-13 Tenant #1 reported 30 Hydrocodone missing. It was discovered missing on 10-31-13 (p.m.).

  According to the Manager's Notes, on 11-1-13 at 9:00 a.m. Tenant #1 approached her with the suspicion 30 Hydrocodone pills were stolen. Tenant #1 was out of the apartment on 10-30-13 from 7:45 a.m. to 5:00 p.m. and was in and out of the apartment on 10-31-13. The notes indicated Tenant #1 was very meticulous and cognitive skills were sharp. Some staff was interviewed in groups using a questionnaire. A private lock was installed on the cabinet door and Tenant #1 and the Manager had the keys. On 11-1-13 at 3:45 p.m. the Manager, the Healthcare Coordinator and the Dementia Coordinator went to Tenant #1's apartment to look for medications and observe the scene. On 11-1-13 at 7:00 p.m. the incident was reported to the Department. On 11-2-13 the police was notified. On 11-4-13 staff interviews continued.

On 11-4-13 the police came to the Program and obtained a statement from Tenant #1. On 11-12-13 it was announced at the Coordinator standup (meeting) it was still under investigation and if anyone had information or saw suspicious behavior to contact the Manager. On 11-15-13 Staff #1 and Staff #2 reported alleged concerns regarding Staff #3 and Tenant #2 and Tenant #3's narcotic medication.

A Resident Missing Item Report Form was completed on 11-1-13 regarding Tenant #1's 30 missing Hydrocodone pills; however, an incident report was not completed.

Tenant #2's file was reviewed. The service plan reflected Tenant #2 received staff assistance with medication administration. The medications were locked in a cupboard or drawer in Tenant #2's apartment.

Tenant #3's file was reviewed. The service plan reflected Tenant #3 received staff assistance with medication administration. The medications were locked in a cupboard or drawer in Tenant #3's apartment.
next day.

According to the Manager's notes, Staff #1 reported Staff #3 did not call her to administer as needed Hydrocodone in particular to Tenant #2. Staff #1 reported when Tenant #2's pendant rang Staff #3 took care of Tenant #2's call even when it was not the hallway Staff #3 was responsible for. Staff #1 reported she had never been called to assist Staff #3 with Tenant #2's as needed medication pass. Tenant #2's narcotic sheets were pulled and it was discovered there were several of Staff #1's initials on the sheets that would have been as needed (medication) which required two staff initials. Staff #1 looked at the dates, times and confirmed the as needed passes on the sheets did not contain Staff #1's handwriting of the initials and someone else had written them. Staff #1's initals would have been present at the 3:00 p.m. times as it was the narcotic count time and Staff #1 was responsible for counting and signing off and those times would include Staff #1's actual initials. Staff #1 reported she witnessed Staff #3 switching medications while administering medications to Tenant #3 on 11-13-13. Staff #1 reported she saw Staff #3 with a medication in one of Staff #3's hands and then punched out Tenant #3's Hydrocodone from the bubble pack with the other hand. Staff #1 reported she saw Staff #3 put the Hydrocodone in Staff #3's pocket and then give Tenant #3 the medication held in the other hand. Staff #1 reported she could see the medication pass transaction.

According to the Manager's notes, Staff #2 confirmed she rarely helped administer as needed Hydrocodone to Tenant #2. Staff #2 reported that on 11-14-13 Staff #3 told Staff #2 that Staff #3 initialed an as needed narcotic dose for Staff #2 when Staff #2 was not present during the administration of the medication. According to Staff #2's written statement, Staff #2 noticed several of her initials that she did not sign.

According to an in-service document regarding medication administration dated 7-18-13, from 7-18-13 forward the administration of an as needed narcotic required two staff. Both staff would count together and document the amount. The only exception was third shift up front. According to a mandatory meeting document dated 12-10-13, two staff was to be present when administering as needed narcotics. Both staff was required to sign or initial the narcotic inventory sheet. As of 12-10-13 third shift needed to call the nurse for all as needed narcotics to get permission to administer.

The narcotic sheet would be placed on the RN's desk so the RN could sign off as the second person the next day.

An incident report was not completed regarding the allegation of falsification of Tenant #2's narcotic record. An incident report was not completed regarding the allegation of switching Hydrocodone while administering medications to Tenant #3.

According to the Event Reporting Guideline, an event of concern might be: injury, potential for injury, elopement, abnormal behavior "ect." A major injury was defined as an injury that resulted in death, admission to a higher level of care, required law enforcement intervention, emergency mental health treatment, report of child abuse, elopement or medication errors of prescription medications. An incident report would be completed by the staff member that first was made aware or was present at the time of the event.

According to the Medication Management Agreement, if a medication error was found an incident report was to be filled out and forwarded to the nurse immediately.

Incident reports were not completed related to Tenant #1's report of missing Hydrocodone pills and allegations regarding Tenant #2 and Tenant #3's narcotic medication and records.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)