IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
48004-C

May 21, 2014

Ms. Michelle Sides, Manager
SunnyBrook of Muscatine
3515 Diana Queen Drive
Muscatine, IA 52761

RE: Final Complaint/Incident Investigation Report, SunnyBrook of Muscatine, Muscatine, Iowa

Dear Ms. Sides:

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, following an investigation by DIA on **May 6 & 7, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation, Service Plans and Nurse Review.

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/emailed to DIA to my attention 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.

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.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

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 #: 48004-C**

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

Date of Complaint/Incident Investigation:

May 6th and 7th, 2014

Monitor(s):

Lori Miner, RN BSN

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:	41
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	41
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	3
Number of tenants with cognitive disorder:	13
Total Population of Program at time of on-site	16
TOTAL census of Assisted Living Program	57

Program History – The program received regulatory insufficiencies in the areas of Staffing, Reporting to the Department, Evaluations, Service Plans, Nurse Review, Policy and Procedures and Tenant Documents during this certification period.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member provoked a tenant, called the tenant names, and took items away from a tenant.

- Monitoring Observation: The Registered Nurse (RN) and the Licensed Practical Nurse (LPN) were interviewed. Neither reported any observations of any staff member which was inappropriate.

  Staff #1, #2, and #3, all Universal Workers who reported working in the dementia unit, reported no observations of any staff member that was inappropriate when working with tenants.

  Observations were made in the dementia unit on the day shift on 5-6-14, the evening shift of 5-6-14, and the day shift of 5-7-14. Staff #1, #2, and #3 was observed as well as Staff #4 and #5. Observations were made in the dementia unit on the day shift of 5-7-14. Observations were made on Staff #1, #3, and #6 during the onsite investigation. No inappropriate behavior was noted on the part of any staff member.

Clinical records were reviewed for Tenants #1, #2, #3, and #4. Tenant #1 no longer resides at the program. The clinical record indicated Tenant #2 has episodes of agitation. Tenant #2 was present during observation periods and was not observed in an agitated state.

During observation, there were no staff members who exhibited inappropriate behavior towards any tenant.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged the program did not have complete records documenting the administration of medications. Medication Administration Records (MARs) were alleged to be inaccurate. It was alleged old medications were not destroyed in a timely manner. It was alleged medications were not secured. It was alleged medications were not administered as ordered.

- Monitoring Observation: Clinical records were reviewed for Tenants #1, #2, #3, and #4. Tenant #1 was discharged from the program in April 2014 and a May 2014 MAR was not applicable. The program provided December through March 2014 MAR's for Tenant #1 upon request. For Tenants #2, #3, and #4, the program was asked to provide MARs for November and December 2013, and January through May 2014. The program was able to provide all MARs except the January 2014 MAR for Tenant #3. One missing MAR did not meet the standard of preponderance of evidence to determine an insufficiency existed.

  MARs for Tenants #1, #2, #3, and #4 were checked against current physician orders. The MARs identified medications as indicated in the orders. The MARs were observed to be correct.

  Staff #1 and #3 reported during interview that medications that were no longer needed were taken to the RN's office. The LPN was interviewed and confirmed medications that were no longer needed were taken to the RN's office.

  In an interview with the RN, she stated medications that were no longer needed were brought to her office. The RN opened the drawer in which she stated medications were placed. There were no medications in the drawer. The RN stated she returned medications to the pharmacy right away.

  A review of the medication destruction policy did not identify a time by which medications would be removed from the program when no longer in use.

  A tour was taken of the program on 5-6-14. The LPN had an office located within the dementia unit. When accompanied by the LPN, the office door was locked. After the LPN unlocked the door, empty bubble packs with tenant names blacked out were observed in the garbage can. There were no medications observed in the LPN's office.

The door to the LPN's office was checked at least three times on 5-6-14 and three times on 5-7-14. On one occasion on 5-7-14 the door to the office was closed but not latched. The door handle was observed to be in a locked position, but had not been pulled securely to engage the lock in the door frame. Medications were observed on an upper shelf on the desk. The LPN, who was in the dementia unit, was notified and the door was immediately pulled shut and secured. The LPN was observed reminding staff members to pull the door shut and make sure it was locked. Of six occasions, the door was observed to be unsecured once.

Staff members were observed in tenant apartments getting medications from locked cabinets.

MARs for Tenants #1, #2, #3, and #4 were checked against current physician orders. The MARs identified medications as indicated in the orders. The MARs were observed to be correct. Medications, which included scheduled and "as needed" medications and narcotics, were documented as administered following physician orders.

- Regulatory Insufficiency: None noted.

C. Staffing

Complaint/Incident Allegation: It was alleged staff members signed documentation which indicated dementia training had been completed when it had not been done.

- Monitoring Observation: Interviews were conducted with Staff #1, #2, #3, and #6. All stated they had received training to work with persons with dementia. None of the staff members interviewed indicated they had been asked to sign training forms without receiving the training.

  The LPN and RN were interviewed. The LPN stated she provided dementia training which included a video, a review of cares needed for tenants in the program's dementia unit, and hands-on training totaling eight hours. The RN confirmed the training provided by the LPN and stated training was provided and staff had not been asked to sign documentation when the training had not been provided.

  Training files were reviewed for UW's #1, #3, #4, #5, and #6. Training files documented four hours of online training as well as tenant-specific and hands-on, for a total of eight hours as required per regulation for persons working in a dementia unit. Dementia training was current for all five employees reviewed. There was no documentation to suggest files had been falsified.

- Regulatory Insufficiency: None noted.

D. Evaluation

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1, a 91 year-old, was admitted on 12-24-13 and had diagnoses of: Osteoporosis, History of Cerebrovascular Accident, Paralysis Agitans, Vascular Dementia, and Chronic Renal Impairment. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline.

  Evaluations of function, cognition, and health were not completed within 30 days of admission.

  Nurse's notes dated 4-27-14 revealed Tenant #1 was more lethargic after an increase of medication for the Paralysis Agitans. On 4-28-14, nurse's notes and interdisciplinary team notes indicated Physical Therapy (PT) had determined Tenant #1 was consistently a routine two-person transfer. Evaluations were not completed with a change of condition.

  Tenant #1 was admitted to the hospital following a fall on 4-29-14. Tenant #1 was diagnosed with a Urinary Tract Infection and did not return to the program.

  Tenant #2, an 83 year-old, was admitted on 6-29-12 and had diagnoses of: Hypertension, Gout, Renal Insufficiency, Dementia, Anxiety, and Coronary Artery Disease. Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #2 resided in the secured dementia unit.

  Interdisciplinary meeting notes dated 11-20-13 documented staff members were to be proactive in redirecting Tenant #2 before Tenant #2 became upset. Notes from a team meeting dated 11-21-13 documented Tenant #2 was exhibiting behaviors and aggression at times. Tenant #2 was described as "dominant" and wanted things done his/her way. An order for Seroquel was requested and received from the physician. Tenant #2 exhibited a change in behavior which required staff intervention and medication changes. Evaluations were not completed with a change of condition.

  Tenant #4, a 76 year-old, was admitted on 3-17-13 and had diagnoses of: Hypertension, Anemia, and Arthritis. Tenant #4 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #4 resided in the secured dementia unit. Tenant #4 was admitted into hospice on 9-20-13 with a blood disorder.

  Nurse's notes dated 2-17-14 and 2-18-14 documented Tenant #4 was experiencing an increase in confusion, and lethargy. An antibiotic was ordered for a suspected urinary infection. Evaluations were not completed with a change of condition.

  Evaluations were not completed within 30 days of admission and with changes of condition for Tenant's #1, #2 and #4.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant was a routine two-person transfer and had not been discharged from the program.

- Monitoring Observation: Clinical records were reviewed for Tenants #1, #2, #3, and #4. Tenant #1 was identified by the program as routinely requiring two persons for transfer. Tenant #1 was discharged from the program on 4-30-14. None of the other files reviewed indicated the tenant exceeded criteria for retention in the program.

  Staff #1, #2, and #3 were interviewed. None of the interviews provided information to suggest any other tenants exceeded criteria for retention.

- Regulatory Insufficiency: None noted.

F. Service Plans

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1 was admitted to the program on 12-24-14 and an initial service plan was completed. A service plan was not completed within 30 days of admission.

  On 4-28-14, Tenant #1 was found to routinely require two persons to assist with transfers. The most recent service plan, dated 4-4-14 was not updated to indicate two-person assist with transfers.

  According to the evaluations completed on 4-14-14, Tenant #1 needed a toileting schedule. The service plan of 4-14-14 indicated Tenant #1 needed to be on a toileting schedule, but did not identify the schedule.

  A fax to the physician dated 4-14-14 documented Tenant #1 was having difficulty swallowing, and requested an order to crush medications. The service plan of 4-14-14 did not identify pills were to be crushed or interventions for difficulty swallowing.

  Service plans for Tenant #1 were not completed within 30 days of admission, were not based on evaluations, and did not meet identified needs of Tenant #1.

During November 2013, Tenant #2 exhibited behaviors and aggression. Seroquel was ordered. The service plan current at the time, dated 6-28-13, was not updated with interventions for behaviors and aggression. The service plan did not meet the identified needs of Tenant #2.

Tenant #3, an 82 year-old, was admitted on 1-21-12 and had diagnoses of: Chronic Airway Obstruction, Anxiety, Asthma, and Osteoporosis. Tenant #3 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #3 resided in the secure dementia unit. A 90-day nurse review was completed on 4-17-14 which indicated Tenant #3 exhibited occasional anxiety and pacing. The current service plan dated 1-20-14 did not identify interventions for anxiety and pacing.

Tenant #4 was admitted to hospice on 3-17-13. According to nurse's notes dated 4-10 and 4-14-14, narcotic pain medications were adjusted. The service plan did not identify interventions for pain or assistance for staff members to identify pain in Tenant #4, a person with dementia.

On 4-29-14, Tenant #4 was prescribed Lorazepam for anxiety and restlessness. The service plan of 3-13-14 indicated Tenant #4 had not been restless but suggested a topic of conversation for redirection. The service plan was not updated to reflect interventions for the anxiety and restlessness that was occurring, and directions to staff on the use of medication for the anxiety and restlessness.

Service plans were not completed within 30 days of admission, were not based on evaluations, and did not meet identified tenant needs.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

G. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #2 had evaluations completed on 3-26-14. According to the nurse's notes dated 3-26-14 a change of condition occurred with the addition of PT following Tenant #2's appointment with a neurologist. According to the physician's order for the PT, Tenant #2 had Parkinsonism that was medication induced. A nurse review was not completed with the change of condition to include a review of medications and any adverse reactions to the medications.

  Notes dated 4-21-14 documented Tenant #2 was discharged from PT. A nurse review was not completed to determine the effectiveness of the therapy and whether any additional services or follow-up was needed.

According to nurse's notes dated 4-30-14, and antibiotic was prescribed for five days for a urinary infection. A nurse review was not completed to determine the effectiveness of the medication.

Tenant #4 was ordered an antibiotic on 2-18-14 for a suspected urinary infection. A nurse review was not completed to determine the effectiveness of the antibiotic once completed.

Nurse reviews were not completed with changes of condition or to monitor recommendations.

- 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 monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and (IAC r. 481-69.27(1))

- Regulatory Insufficiency: 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))

H. Food Service

Complaint/Incident Allegation: It was alleged food items were not dated or labeled when stored.

- Monitoring Observation: The program provided to the surveyor a copy of the current food license which was issued to the assisted living and memory care. A phone call was made to the issuer of the license. The food inspector indicated any food storage area in the program was reviewed by an inspector. The documentation and phone call indicated the program had a licensed kitchen in both the general population and dementia units.

  A food storage area including refrigerator was observed in the dementia unit. Food items were observed to be dated and labeled. Ice cream in the freezer was not dated. According to the food inspector, ice cream was not required to be dated.

  The kitchen in the general population and dementia unit was licensed and subject to inspections by the local public health department. Food items were observed to be labeled and dated.

- Regulatory Insufficiency: None noted.