IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47554-C

July 8, 2014

Ms. Brandi Logli, Manager
Sunnybrook Assisted Living
3000 West Madison Avenue
Fairfield, IA 52556

RE: Final Complaint/Incident Investigation Report – Sunnybrook Assisted Living, Fairfield, IA

Dear Ms. Logli:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of June 25 and 26, 2014, 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:

Brandi Logli, Manager
SunnyBrook Assisted Living
3000 West Madison Avenue
Fairfield, Iowa 52556

Complaint/Incident Intake #: 47554-C

Date of Complaint/Incident Investigation:

June 25 and 26, 2014

Monitor(s):

Wendy E. Kuhse, RN, BS

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:	3
Total Population of Program at time of on-site	46
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	55

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

A. Evaluation

Complaint/Incident Allegation: It was alleged a tenant, who might not be appropriate for assisted living level of care, was walking alongside a highway and staff were not aware the tenant had left the premises.

Monitoring Observation: Tenant #1, an 85 year old, was admitted to the general population 9-7-07. Tenant #1 had diagnoses of: Hypertension, Dementia, Gastrointestinal Upset, and a Fall with Hip Fracture on 8-16-11. Tenant #1 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive impairment.

According to a 90 day nurse review dated 5-19-14 Tenant #1 was able to ambulate independently with a wheeled walker, and was independent with all activities of daily living. Tenant #1 had been started on a new medication and Tenant #1's mood had improved greatly. The nurse review noted there were no changes in Tenant #1's cognitive, physical or health status and no changes in the service plan at this time.

During an interview on 6-26-14 at 9:29 a.m., Tenant #1 stated he/she "wanders' around the Program, enjoys being outdoors and at times walks in areas outside the immediate premise of the Program. Tenant #1 was noted to have a collection of disposed items (old papers, tissues, milk jug, etc.) Tenant #1 had picked up while walking. Tenant #1 confirmed that Tenant #1's car was at the program, but Tenant #1 could not currently drive the car as the battery was dead. Tenant #1 could not readily recall a time he/she

had started to "walk to town", but did recall that Tenant #1 wanted to cash a check, but could not recall specific dates. Tenant #1 also stated he/she did not understand why more tenants didn't go outside the building.

Tenant #3, a 84 year old, was admitted to the general population on 6-1-12. Tenant #3 had diagnoses of: Diabetes Mellitus, Type 2, Mechanical Heart Failure, Osteoarthritis, Renal Insufficiency and Polymyalgia Rheumatica. Tenant #3 was staged at a one on the GDS which indicated no deficit in cognition.

During an interview at 7:30 a.m. on 6-26-14, Tenant #3 stated he/she did have a car at the Program and did come and go as desired. Tenant #3 stated he/she did not take other tenants along as passengers and had not picked up other tenants walking outside the premises of the Program.

Tenant #4, a 89 year old, was admitted to the general population on 7-27-12. Tenant #4 had diagnoses of: Total Right Hip Repair, Acute Pneumonia, Bronchitis, and Fractured Wrist with Surgical Repair. Tenant #4 was staged at a one on the GDS which indicated no deficit in cognition.

During an interview at 8:10 a.m. on 6-26-14, Tenant #4 stated he/she had a car and occasionally will take another tenant on an outing. Tenant #4 stated Tenant #4 asks a male acquaintance to ride with Tenant #4 once month to "monitor" Tenant #4's driving abilities and make sure Tenant #4 is able to drive safely. Tenant #4 stated on one occasion, Tenant #4 noted another Tenant walking alongside the road (off the Program's premise) and stopped and picked up the Tenant and escorted that Tenant to the desired destination. Tenant #4 didn't see any problems with the incident stating they (tenants) were free to come and go from the Program as they pleased.

Tenants in the general population were free to come and go as they desired, and no tenant was identified as exceeding level of care for assisted living.

- Regulatory Insufficiency: None noted.

B. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged that the Program had a problem with the fire and/or sprinkler system and tenants were relocated to another program while repairs were being made. It was alleged that the Program failed to report this to the Department.

- Monitoring Observation: During an interview on 6-25-14 at 3:32 p.m., the Maintenance man (Staff #1) stated quite a few months ago the program had problems with their fire and sprinkler system. They had busted water pipes and the Gardens (dementia unit of the Program) was flooded. Staff #1 stated as a result, the tenants in that area of the building were transported to a sister program where SunnyBrook staff and the regular program staff together assisted in meeting the needs of the tenants. During this time, repairs in the Gardens were finalized. Once completed and finalized with the fire marshal, the tenants returned to the Gardens.

Documentation from a copy of the "Online Abuse or Incident Reporting" indicated the Department received notification from SunnyBrook Assisted Living on 12-14-13 at approximately 12:00 p.m. that there was a fire sprinkler leak. Corrective action taken was the evacuation of tenants, clean up and repairs.

- Regulatory Insufficiency: None noted.