IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

October 18, 2012

Complaint/Incident Intake #: 39990-I

Ms. Dana Yerington, Manager
SunnyBrook of Muscatine
3515 Diana Queen Drive
Muscatine, IA 52761

RE: Final Recertification Monitoring Evaluation & Complaint/Incident Investigation Report – SunnyBrook of Muscatine, Muscatine, IA

Dear Ms. Yerington:

Enclosed is the **Final Recertification Monitoring Evaluation & 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 completed the review of your Plan of Correction (POC) in response to the **Preliminary Recertification Monitoring Evaluation & Complaint/Incident Investigation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0288** with effective dates of **October 15, 2012** through **October 14, 2014**.

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

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(515) 281-5714
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Telephone Number for the Hearing Impaired: (515) 242-6515

If you have any questions in regard to this certification, 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 Recertification Monitoring Evaluation & Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 39990-I

Dana Yerington, Manager
SunnyBrook of Muscatine
3515 Diana Queen Drive
Muscatine, IA 52761

Date of Monitoring Visit & Complaint/Incident Investigation:

August 9 & 13, 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:	53
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	54

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	65

Tenant/Family Satisfaction Results – A community meeting was held with 18 tenants. The tenants said they liked everything about living at the Program; they had a roof over their heads, food was provided, services were tremendous and there were people wanting to help the tenants. It was the next best place to be if one couldn't be at home. Housekeeping services were described as super and maintenance was wonderful and items were fixed right away. The tenants said staff did a fabulous job with laundry and it was much improved over a year ago. Nursing services were available and was described as very good. When one of the tenants fell after hours, the nurse came in right away. Staff responded within 5 to 10 minutes when called. Staff was described as wonderful and very good, knew what services to provide and was trained appropriately. Tenants said the food was wonderful, a lot was served and sometimes too much food. There was a variety of meats, vegetables and desserts and one could get anything one wanted. Staff served tenants appropriately. Hot foods were nice and hot but the evening meal could be hotter. Food could be sent back to be reheated if needed. Meat was delicious and tender. A comment was made that it was impossible to please everyone. Tenants said there was plenty of activities, sometimes too many. All tenants received a monthly calendar and said the activities staff did a good job. Staff always asked what tenants would like to do. They enjoyed playing cards, Dominoes, video game bowling and going on outings. Tenants said they felt safe, made their own decisions, were generally satisfied with the Program and would recommend it to others. Tenants said they were advised to go the Director if they needed anything. Tenants indicated they would like to have the front desk staffed on the weekends. It was also requested more chairs be purchased to be used for meetings.

Program History – The Program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made observations detailed in the following areas.

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

A. Program Reporting to the Department

- Monitoring Observation: Four tenant files were reviewed.

  Tenant #1, an 89 year old, was admitted on 5-16-11 and diagnoses include: Hypertension, Dementia, Arthritis, Reflux and Pain (secondary to fall). Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. Tenant #1 was discharged from the Program.

  According to an Event Report on 5-19-12 at 2:20 p.m., Tenant #1 was found on the floor in front of the chair. Tenant #1 stated Tenant #1 fell out of bed, scooted across the room to the door and then back to the chair. Tenant #1 had an emergency pendant on; however, Tenant #1 forgot to use it. Vitals were obtained and Tenant #1 was assisted to stand and then sat in the chair.

  Nurse's Notes dated 5-19-12 at 2:25 p.m., indicated a nurse received a call from staff who stated Tenant #1 was found on the floor. Tenant #1 complained of pelvic area pain and no further injuries were noted. Family was notified and was in agreement with monitoring Tenant #1 and no emergency room (ER) transfer at that time for further evaluation. Tenant #1 was able to move all extremities. According to Nurse's Notes dated 5-19-12 at 6:00 p.m., a nurse received a call from staff regarding Tenant #1. Tenant #1 complained of significant pain to "crotch" area. Tenant #1 was transported to the ER via ambulance. Nurse's Notes dated 5-19-12 at 8:00 p.m., indicated Tenant #1 had a pelvic fracture and was being admitted for observation. Nurse's Notes dated 5-21-12 at 4:00 p.m. indicated Tenant #1 would be transferred to a nursing facility for physical therapy (PT). According to Nurse's Notes dated 6-27-12, Tenant #1 returned to the Program.

  An annual service plan was updated and dated 5-16-12, prior to Tenant #1's fall on 5-19-12. The service plan indicated Tenant #1 could transfer self to and from the wheelchair and was assist of one to transfer. Tenant #1 required assist of one with ambulation with a gait belt as knees buckle. Tenant #1 needed to walk up and back to meals. The service plan identified Tenant #1 had a history of falls, used a wheelchair for longer distances and had a walker.

  Tenant #1 had a GDS of four, which indicated moderate cognitive decline and resided in the dementia unit. Tenant #1 had a fall, was sent out to the ER, was diagnosed with a pelvic fracture and was admitted. Tenant #1 was transferred to a nursing facility for rehabilitation and returned to the Program on 6-27-12. Tenant #1's service plan indicated Tenant #1 required assistance with ambulation. The incident was not reported to the Department.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: Of any accident causing major injury. For the purpose of this rule, "major injury" shall also mean a substantial injury. (IAC r. 481-67.4(1))

B. Staffing

Complaint/Incident Allegation: The Program reported a tenant fell and staff found the tenant on the floor. The tenant had a rug burn on the leg and a scrape along with a bruise on the forehead above the left eyebrow. The tenant was seen at urgent care and three sutures were applied. The next day staff noticed the tenant was not acting like himself/herself and the tenant was transferred to the ER. The tenant had a small brain bleed and was transferred to another hospital.

- Monitoring Observation: Tenant #1's file was reviewed. According to an Event Report on 7-2-12 at 3:50 a.m., staff heard what sounded like someone knocking. Staff responded and followed the sound to Tenant #1's apartment. Tenant #1 was on the floor right inside the door next to the wheelchair. Tenant #1 had a rug burn on Tenant #1's leg and a scraped and bruised forehead above the left eyebrow. The scrape on the forehead was cleaned and Tenant #1 was assisted up off the floor. The nurse was notified at 3:55 a.m. and Tenant #1's family was notified at 9:20 a.m.

  According to Nurse's Notes dated 7-2-12 at 8:40 a.m., Nurse #1 received a call that morning regarding Tenant #1 and a fall out of bed at about 3:30 a.m. Tenant #1 had an abrasion and 1.5 cm above the left eye. The area was cleansed, triple antibiotic ointment and gauze dressing was applied. Tenant #1 denied pain, vitals were obtained and family was notified. A message was left to find out where family wanted Tenant #1 to be seen for possible sutures. According to Nurse's Notes dated 7-2-12 at 4:00 p.m., family took Tenant #1 to urgent care and three sutures were applied to laceration above the left eye. Tenant #1 denied pain and the dressing was clean, dry and intact. Nurse's Notes dated 7-2-12 at 6:15 p.m., was rechecked by Staff #1, a licensed practical nurse, before the end of the shift and Tenant #1 was alert, and oriented per Tenant #1's normal. Tenant #1 denied a headache and pain. Tenant #1 did not exhibit any mental status changes but staff would continue to monitor Tenant #1. Nurse's Notes dated 7-3-12 at 11:00 a.m., indicated Tenant #1 complained of a headache, which Tenant #1 had on previous occasions. An as needed medication was given and was effective. Nurse's Notes dated 7-3-12 at 1:00 p.m., indicated Tenant #1 exhibited an increase in confusion, grips were equal, Tenant #1 was able to follow commands, pupils were equal, reactive to light. Tenant #1 was smiling and talkative. Tenant #1 denied a headache, denied pain and denied an upset stomach. Nurse's Notes dated 7-3-12 at 2:15 p.m., indicated Tenant #1 continued to have increased confusion and Staff #1 noticed increased restlessness and thought Tenant #1 needed to be seen. Family was notified and agreed to have Tenant #1 sent to the ER for evaluation. Nurse's Notes dated 7-3-12 at 6:30 p.m., indicated Tenant #1 had a minor head bleed and was transferred to another hospital. Nurses Notes dated 7-6-12 at 2:30 p.m. indicated Tenant #1 was going to be discharged from a hospital and would transfer to a nursing facility.

Staff #2 worked at the time of the incident. She said around 4:00 a.m. she heard what sounded like someone knocking. The noise came from Tenant #1's apartment. Tenant #1 was found right inside the door sitting on Tenant #1's buttocks. There was a gash above the left eye. She called the nurse on call, Nurse #1. Nurse #1 did not answer the phone and Staff #2 left a message. She called Staff #1 and Staff #1 did not answer and Staff #2 left a message. Staff proceeded to get Tenant #1 up, got into the wheelchair and into bed. Tenant #1 was asked if Tenant #1 had pain and Tenant #1 had no complaints of pain except where the gash was located. Staff #2 checked on Tenant #1 about every 20 minutes and Tenant #1 was sleeping. Staff #2 went to administer a pill to Tenant #1 at 6:00 a.m. She said Tenant #1 was disoriented. Staff #2 called the nurse on call, Nurse #1 and left a message and called Staff #1 and left a message. She did not receive any answers. Staff #2 informed first shift what happened. Staff #2 said she did not receive any calls back from the nurse on call that day. Staff #2 said she had called the on call nurse before and that was the only time she did not receive an answer. She came to the Program at about 9:00 a.m. and saw Staff #1 and spoke with Staff #1.

Staff #1 said Nurse #1 was on call at the time of the incident. She said Staff #2 told her about it Monday about 8:30 a.m. Staff #2 told Staff #1 that Tenant #1 had fallen and had a gash above the eye and there were no other changes in condition. Nurse #1 had assessed Tenant #1 and had thought Tenant #1 probably needed to be seen and checked out. Staff #1 said at that time, no other changes were noted and vitals and neurological checks were within normal limits (WNL). Family was notified and took Tenant #1 to be seen. Tenant #1 returned the same day with two to three sutures. Tenant #1 had no complaints of pain and it was not until the next day Tenant #1 was a little more confused, restless and started to complain of a headache. Tenant #1 went to the ER, had a head computed tomography that identified a small intracranial bleed. Tenant #1 was transferred and admitted to another hospital and then discharged to a nursing facility. Staff #1 said Staff #2 reported no changes besides the gash above the eye. When neurological checks were done they were WNL. Tenant #1 complained of headache, had increased restlessness and increased confusion the day after the fall. Tenant #1 did not have any vomiting, had no changes in gait and did not complain of nausea. Tenant #1 was not going to return to the Program.

The Manager said she came in on Monday and was told Tenant #1 had fallen. Staff #1 contacted family and family was going to take Tenant #1 to urgent care as Tenant #1 had a small cut. At that time neurological checks were okay. The next day Staff #1 said Tenant #1 was not Tenant #1's normal self and wanted Tenant #1 checked out. Tenant #1 went to the ER and was diagnosed with an intracranial bleed. She said at that time the incident was reported to the Department. She said the on call expectation was that the ringer was left on and a call was returned as soon as the message was received.

A written nursing on call schedule indicated Nurse #1 was on call 7-1-12, 7-2-12 and 7-3-12. Nurse #1 no longer worked at the Program. The Program provided a schedule of nursing on call coverage for the month of July. The Health Care Coordinator was hired on 8-6-12.

Tenant #1 had another fall on 5-19-12. Nurse's Notes dated 5-19-12 at 8:00 p.m. indicated Tenant #1 had a pelvic fracture and was being admitted for observation.

Nurse's Notes dated 5-21-12 at 4:00 p.m. indicated Tenant #1 would be transferred to a nursing facility for PT. According to Nurse's Notes dated 6-27-12, Tenant #1 returned to the Program.

The Program notified the Department of the incident; once it was determined Tenant #1 sustained a significant injury. An Event Report was completed related to the incident.

Tenant #1 had a fall and staff contacted the nurse on call twice during the shift and was unable to reach the nurse on call. Tenant #1's family was not notified until 9:20 a.m. Tenant #1 did not have an observed change in condition until the day after the fall: however, a nurse was not available when staff called regarding Tenant #1's fall.

- 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))

C. Tenant Documents

Monitoring Observation: The table below represents physician ordered treatments not completed or not documented as completed. Medication Administration Records (MARs) were reviewed from May 2012 to August 2012 and indicated the following:

TENANT	TREATMENT	DATE	CHARTING ON MAR
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	5-8-12 a.m. and p.m.	a.m. did not put on had to wash; p.m. none available to take off
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	5-20-12 a.m. and p.m.	a.m. none available; p.m. none available
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	5-21-12 a.m. and p.m.	a.m. none available; p.m. none available
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	5-26-12 a.m.	a.m. already on
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	6-12-12 p.m.	p.m. not on and not taken off; Charted as on in the a.m.
Tenant #2	Geri-sleeves to arms on in a.m. and off in the p.m.	6-13-12 a.m. and p.m.	a.m. not found; p.m. not on
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	6-14-12 a.m. and p.m.	a.m. not found and not on; p.m. circled on front of

			the MAR and no explanation on the back of the MAR
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	6-29-12 a.m. and p.m.	a.m. in washer, not on; p.m. not on
Tenant #2	Geri-sleeves to arms on in a.m. and off in p.m.	6-30-12 p.m.	p.m. not on; Charted as on in a.m.
Tenant #2	Ted Hose on in a.m. and off in p.m.	7-2-12 a.m. and p.m.	a.m. not on, still wet; p.m. not on
Tenant #2	Ted Hose on in a.m. and off in p.m.	7-4-12 p.m.	p.m. not on
Tenant #2	Ted Hose on in a.m. and off in p.m.	7-7-12 a.m. and p.m.	a.m. not on, wet; p.m. not on
Tenant #2	Geri-sleeves on in a.m. and off in p.m.	7-18-12 a.m. and p.m.	a.m. not on, wet; p.m. not on
Tenant #2	Geri-sleeves on in a.m. and off in p.m.	7-28-12 p.m.	p.m. not on; Charted as on in a.m.
Tenant #2	Ted Hose on in a.m. and off in p.m.	8-6-12 p.m.	p.m. none available to take off; Charted as on in a.m.
Tenant #2	Ted Hose on in a.m. and off in p.m.	8-9-12 a.m.	a.m. not on, still wet; Charted as off in p.m.
Tenant #2	Ted Hose on in a.m. and off in p.m.	8-11-12 and 8-12-12 a.m. and p.m.	Not on/not found
Tenant #2	Geri-sleeves on in a.m. and off in p.m.	8-1-12 a.m. and p.m.	a.m. not on, in laundry; p.m. not on
Tenant #2	Geri-sleeves on in a.m. and off in p.m.	8-2-12 p.m.	p.m. not put on in a.m.; Charted as on in a.m.

Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)(i))