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
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

May 26, 2015

Incident Intake #: 52583-M

Ms. Sarah Martin, Director
Sunnybrook of Mt. Pleasant
1406 East Linden Drive
Mount Pleasant, IA 52641

RE: Final Incident Investigation & Recertification Monitoring Evaluation Report – Sunnybrook of Mt. Pleasant, Mt. Pleasant, IA

Dear Ms. Martin:

Enclosed is the **Final Incident Investigation & Recertification Monitoring Evaluation 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 a survey by DIA on **April 30 & May 4 - 6, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Record Checks, Service Plans and Food Service..

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.

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.

Also enclosed you will find the Assisted Living Program Certificate **S0208** with effective dates of **February 17, 2015** through **February 16, 2017.**

If you have any questions in regard to this 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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0208	A. BUILDING: _____ B. WING _____	C 05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK AL OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 35 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 36 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 12 Total Population of Program at time of on-site: 12 TOTAL census of Assisted Living Program: 48 A recertification visit and investigation of Incident #52583-M was completed. There were regulatory insufficiencies related to the recertification visit and Incident #52583-M.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. 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.	A 003		

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to complete incident reports per the Program's policy for two tenants (Tenants #1 and #3). Incident reports were not completed per Program policy for missing tenant medications and for tenant behavior. (Recertification and Incident #52583-M) 1. Tenant #1, a 94 year old, was admitted on 7-15-08 and diagnoses included: macular degeneration, cerebral vascular accident (right sided weakness), transient ischemic attack, osteoarthritis, right shoulder without cartilage, restless leg syndrome and renal insufficiency. The service plan reflected Tenant #1 was independent with medications and Tenant #1 had a friend who set up medications in a planner weekly. According to a Program documents, on 2-9-15 Tenant #1's friend who set up Tenant #1's medications reported Tenant #1 had Hydrocodone missing. On 2-18-15 Tenant #1's friend who set up Tenant #1's medications reported Tenant #1 had Hydrocodone missing. On 2-22-15 Tenant #1 reported pills missing. On 3-25-15 it was reported Tenant #1's lock on the medication cabinet had allegedly been tampered with and Hydrocodone was missing. Incident reports were not completed when it was reported Tenant #1 was missing Hydrocodone. 2. Tenant #3, an 88 year old, was admitted on 6-7-13 and diagnoses included: anxiety, depression, Alzheimer's disease, hypertension, esophageal reflux and history of diverticulitis. Tenant #3 was staged at a five on the Global Deterioration Scale, which indicated moderately	A 003		

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A 003	Continued From page 2 severe cognitive decline. Tenant #3 resided in the dementia unit. According to Nurse's/Care Notes dated 3-30-15, staff called the nurse on 3-29-15 at 5:00 p.m. and reported Tenant #3 had increased agitation. Tenant #3 began chasing staff with a fork. Staff was instructed to have a different staff try redirecting Tenant #3 by going for a walk. There were no as needed medications available. Staff was able to redirect Tenant #3 by removing Tenant #3 from the situation and lying down to rest. The doctor was notified and new order was received to obtain an urinalysis. An incident report was not found related to the incident on 3-29-15 when Tenant #3 had increased agitation and chased staff with a fork. 3. According to the Program's Event Reporting policy, documentation for any event that had the potential concern for any tenant, staff or visitor. An event of concern might be: injury, elopement and abnormal behavior. An incident report would be completed by the staff first made aware of or who was present at the time of the event. The reports initially would be kept in a binder in the nursing office for 90 days and then kept in the incident report file. Incident reports would be completed by staff before leaving the building at the end of their shift. Completed incident reports would be left in the nursing office.	A 003		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety	A 118		

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A 118	Continued From page 3 perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on review of staff files and Program documents the Program failed to complete a criminal history check and an abuse registries background check prior to employment for one staff (Staff A). Criminal history and abuse registries background checks were not completed prior to hire for one staff. (Recertification) 1. Staff A, a caregiver, was hired on 8-21-14. A criminal history background check completed by the Department of Public Safety (DPS) and abuse registries background check completed by the Department of Human Services (DHS) was not completed prior to employment. A criminal history background check completed by DPS and abuse registries background check completed by DHS was dated 5-5-15 (at the time of the onsite), which revealed there was no history or further research required. Staff A had worked at the Program twice previously, hired on 11-16-09 and resigned on 9-10-10 and hired again on 12-27-10 and resigned on 10-25-12 before being re-hired on 8-21-14. The criminal history background check by DPS and abuse registries check by DHS was last completed on 12-20-10 and did not reveal a history or further research required. 2. Time card records for Staff A were provided	A 118		

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A 118	Continued From page 4 and revealed Staff A received paid wages in August of 2014. 3. The Program's Hiring and Staffing Policy indicated the hiring practices were based on clearance through State of Iowa regulations based on background checks prior to offering a job including: criminal, dependent adult abuse and child abuse. Proof of the background check should be maintained in the personnel file. If a prospective employee had a criminal history or abuse background an evaluation must be conducted by DHS prior to employment to assess for employment prohibition.	A 118		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) 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. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to develop service plans that were designed to meet the specific service needs of the individual tenant and updated at least annually for two tenants (Tenant #1 and #3). The service plan was not designed to meet the specific needs for Tenant #1 and was	A 083		

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A 083	Continued From page 5 not updated as least annually for Tenant #3. (Recertification and Incident #52583-M) 1. Tenant #1, a 94 year old, was admitted on 7-15-08 and diagnoses included: macular degeneration, cerebral vascular accident (right sided weakness), transient ischemic attack, osteoarthritis, right shoulder without cartilage, restless leg syndrome and renal insufficiency. January through May 2015 (at the time of the investigation) treatment administration records (TARs) reflected Tenant #1 received staff assistance with an eye drop daily at 9:00 a.m. The service plan reflected Tenant #1 was independent with medications and Tenant #1 had a friend who set up medications in a planner weekly. The service plan did not reflect the eye drop daily. Tenant #1 had a lamp used at meals and staff took it to the dining room and returned it to Tenant #1's apartment. The use of the lamp and staff assistance with lamp was not reflected on the service plan. The service plan was not designed to meet the specific service needs of Tenant #1. 2. Tenant #3, an 88 year old, was admitted on 6-7-13 and diagnoses included: anxiety, depression, Alzheimer's disease, hypertension, esophageal reflux and history of diverticulitis. Tenant #3 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #3 resided in the dementia unit. Cognitive, health and functional evaluations were completed on 6-3-14. Nurse's/Care Notes dated 6-3-14 indicated it was the annual assessment. The note indicated the service plan was reviewed and remained current. The most current service plan found for Tenant #3 was dated 2-3-14 and it was noted as completed for a change of	A 083		

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A 083	Continued From page 6 condition. The service plan was signed by a health care professional and Tenant #3's legal representative. A service plan was not completed as least annually for Tenant #3. 3. According to the Program's ISP (Individualized Service Plans) Policy, the service plan would be based on evaluations and designed to meet the tenant's needs. When a tenant needed personal care or health-related care, the service plan should be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less annually.	A 083		
A 205	481-69.28(6) Food Service 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. This REQUIREMENT is not met as evidenced by: Surveyor: Cummins, Stephanie Based on observation, Program documents and staff interviews the Program failed to meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food. Warewashing was completed in the dementia unit after the breakfast meal. The dementia unit did not have a commercial dishwasher or a three compartment sink to provide warewashing. (Recertification) 1. According to the ALP Monitoring Entrance	A 205		

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A 205	Continued From page 7 Form, the Program consisted of a general population and dedicated dementia unit. 2. The Program had a Food Service Establishment License issued on 11-20-14 and it had an expiration date of 8-26-15. 3. According to an interview with the Dietary Supervisor on 5-5-15 at 8:56 a.m., three meals per day were served and the food was prepared in the main kitchen. Toast and possibly oatmeal were prepared in the dementia unit. In the dementia unit after breakfast dishes were washed in the dementia unit. For the lunch and supper meals dishes were brought back to the main kitchen and were washed. In the dementia unit the dishes were soaked in a sanitizer solution and then washed with dish soap (in a sink). There had not been any food related illnesses. 4. According to an interview with Staff B, caregiver, on 4-30-15 at 10:38 a.m. and approximately 12:15 p.m., breakfast dishes were washed in the dementia unit. Staff B said there was not a commercial dishwasher in the dementia unit. Staff B said after lunch dishes would go to the main kitchen. Staff B said there were no tenant complaints regarding the meals except there was too much food. 5. According to observation on 4-30-15 at approximately 12:15 p.m., a dishwasher was not observed in the dementia unit kitchen area. A standard sink (two compartments) was observed in the kitchen area. 6. According to the Program's Service of Food policy, all food would be served in a manner to ensure food safety. Employees involved in the service of food must observe the following	A 205		

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A 205	Continued From page 8 procedures including: to clean and sanitize utensils before using them and use separate utensils for each food items.	A 205		

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A 118	Continued From page 3 perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on review of staff files and Program documents the Program failed to complete a criminal history check and an abuse registries background check prior to employment for one staff (Staff A). Criminal history and abuse registries background checks were not completed prior to hire for one staff. (Recertification) 1. Staff A, a caregiver, was hired on 8-21-14. A criminal history background check completed by the Department of Public Safety (DPS) and abuse registries background check completed by the Department of Human Services (DHS) was not completed prior to employment. A criminal history background check completed by DPS and abuse registries background check completed by DHS was dated 5-5-15 (at the time of the onsite), which revealed there was no history or further research required. Staff A had worked at the Program twice previously, hired on 11-16-09 and resigned on 9-10-10 and hired again on 12-27-10 and resigned on 10-25-12 before being re-hired on 8-21-14. The criminal history background check by DPS and abuse registries check by DHS was last completed on 12-20-10 and did not reveal a history or further research required. 2. Time card records for Staff A were provided	A 118	The Executive Director will review the State Regulations on record checks and ensure that record checks are complete for all new hires. The Executive Director will also ensure all record checks are complete prior to hire date by doing the record checks themselves. After the initial interview the ED will have the new hire come back in and fill out appropriate paperwork and complete the online background check. The regional director of operations will review 10% of staff	5/27/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0208	A. BUILDING: _____ B. WING _____	C 05/06/2015

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A 118	Continued From page 4 and revealed Staff A received paid wages in August of 2014. 3. The Program's Hiring and Staffing Policy indicated the hiring practices were based on clearance through State of Iowa regulations based on background checks prior to offering a job including: criminal, dependent adult abuse and child abuse. Proof of the background check should be maintained in the personnel file. If a prospective employee had a criminal history or abuse background an evaluation must be conducted by DHS prior to employment to assess for employment prohibition.	A 118	files quarterly.	
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) 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. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to develop service plans that were designed to meet the specific service needs of the individual tenant and updated at least annually for two tenants (Tenant #1 and #3). The service plan was not designed to meet the specific needs for Tenant #1 and was	A 083		

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A 083	Continued From page 5 not updated as least annually for Tenant #3. (Recertification and Incident #52583-M) 1. Tenant #1, a 94 year old, was admitted on 7-15-08 and diagnoses included: macular degeneration, cerebral vascular accident (right sided weakness), transient ischemic attack, osteoarthritis, right shoulder without cartilage, restless leg syndrome and renal insufficiency. January through May 2015 (at the time of the investigation) treatment administration records (TARs) reflected Tenant #1 received staff assistance with an eye drop daily at 9:00 a.m. The service plan reflected Tenant #1 was independent with medications and Tenant #1 had a friend who set up medications in a planner weekly. The service plan did not reflect the eye drop daily. Tenant #1 had a lamp used at meals and staff took it to the dining room and returned it to Tenant #1's apartment. The use of the lamp and staff assistance with lamp was not reflected on the service plan. The service plan was not designed to meet the specific service needs of Tenant #1. 2. Tenant #3, an 88 year old, was admitted on 6-7-13 and diagnoses included: anxiety, depression, Alzheimer's disease, hypertension, esophageal reflux and history of diverticulitis. Tenant #3 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #3 resided in the dementia unit. Cognitive, health and functional evaluations were completed on 6-3-14. Nurse's/Care Notes dated 6-3-14 indicated it was the annual assessment. The note indicated the service plan was reviewed and remained current. The most current service plan found for Tenant #3 was dated 2-3-14 and it was noted as completed for a change of	A 083	The Executive Director and Health Services Director will review the State Regulations on service plans and ensure that each tenant service plan is individualized and meet the needs of the tenant. The service plan will be reviewed and updated 30 days after move in by the RN and at minimum annually there after. The service plan will be updated with any change in condition. The Regional Director of Operations will review 10% of Nursing Charts including service plans quarterly while doing her quality assurance.	5/27/15

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A 083	Continued From page 6 condition. The service plan was signed by a health care professional and Tenant #3's legal representative. A service plan was not completed as least annually for Tenant #3. 3. According to the Program's ISP (Individualized Service Plans) Policy, the service plan would be based on evaluations and designed to meet the tenant's needs. When a tenant needed personal care or health-related care, the service plan should be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less annually.	A 083		
A 205	481-69.28(6) Food Service 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. This REQUIREMENT is not met as evidenced by: Surveyor: Cummins, Stephanie Based on observation, Program documents and staff interviews the Program failed to meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food. Warewashing was completed in the dementia unit after the breakfast meal. The dementia unit did not have a commercial dishwasher or a three compartment sink to provide warewashing. (Recertification) 1. According to the ALP Monitoring Entrance	A 205		

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A 205	Continued From page 7 Form, the Program consisted of a general population and dedicated dementia unit. 2. The Program had a Food Service Establishment License issued on 11-20-14 and it had an expiration date of 8-26-15. 3. According to an interview with the Dietary Supervisor on 5-5-15 at 8:56 a.m., three meals per day were served and the food was prepared in the main kitchen. Toast and possibly oatmeal were prepared in the dementia unit. In the dementia unit after breakfast dishes were washed in the dementia unit. For the lunch and supper meals dishes were brought back to the main kitchen and were washed. In the dementia unit the dishes were soaked in a sanitizer solution and then washed with dish soap (in a sink). There had not been any food related illnesses. 4. According to an interview with Staff B, caregiver, on 4-30-15 at 10:38 a.m. and approximately 12:15 p.m., breakfast dishes were washed in the dementia unit. Staff B said there was not a commercial dishwasher in the dementia unit. Staff B said after lunch dishes would go to the main kitchen. Staff B said there were no tenant complaints regarding the meals except there was too much food. 5. According to observation on 4-30-15 at approximately 12:15 p.m., a dishwasher was not observed in the dementia unit kitchen area. A standard sink (two compartments) was observed in the kitchen area. 6. According to the Program's Service of Food policy, all food would be served in a manner to ensure food safety. Employees involved in the service of food must observe the following	A 205	The Dining Services Director will review state and local health laws as well as our company policy on food service. The Dining Services Director and Executive Director will ensure that all dishes are cleaned and sanitized appropriately in the kitchen. The Dining Services Director will follow up with staff that this is being done. The regional director of operations will be in quarterly to do a quality assurance on the kitchen and make sure company policies are being followed.	5/27/15

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A 205	Continued From page 8 procedures including: to clean and sanitize utensils before using them and use separate utensils for each food items.	A 205		