

6/25/18

PRINTED: 05/30/2018
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2018
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NAME OF PROVIDER OR SUPPLIER SUNNYBROOK AL OF MT PLEASANT	STREET ADDRESS, CITY, STATE, ZIP CODE 1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641
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A 000	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>General Population Number of tenants without cognitive disorder: 31 Number of tenants with cognitive disorder: 1</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 8</p> <p>Total Census of Assisted Living Program for People with Dementia: 40</p> <p>No regulatory insufficiencies were cited regarding regarding the investigations of 74140-C or 73925-C.</p> <p>The following regulatory insufficiencies were cited during the investigations of 73871-C, 75006-M, 75080-A and 75118-M.</p>	A 000		
A 012	<p>481-67.3(1) Tenant Rights</p> <p>481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, the program failed to ensure 7 of 12 tenants reviewed were treated</p>	A 012		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DD 6/25/18

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A 012	<p>Continued From page 1</p> <p>with consideration, respect and dignity (Tenants #2, #4, #5, #6, #9, #10, #11 and #12). Findings follow:</p> <p>1. Interviews conducted throughout the investigation revealed 5 current staff, 1 former staff and 2 tenants with concerns regarding Staff A. These concerns included:</p> <p>On 3/5/18 at 12:20 PM Staff C reported Tenant #2 told her of being picked up out of bed by Staff A and held up with his/her legs dangling. Tenant #2 also reported Staff A made him/her walk too fast. Staff C stated Tenant #2 shook and became visibly upset when Staff A was around. Staff C also heard Staff A yell at Tenant #4 about not cooperating with his/her service plan. Staff A and Tenant #4 were in the front office. Staff C was approximately 75 feet away in the nearby dining room.</p> <p>On 3/5/18 at 10:32 AM Staff D reported being told by Tenant #2 he/she had been pulled out of bed and manhandled by Staff A. Staff D stated she witnessed Staff A walk with Tenant #2 to the dining room and heard Staff A say "Let's go" in a loud voice. Tenant #2 was shaking and out of breath when he/she arrived at the dining room. Staff D also reported Staff A yell at Tenant #4 in Staff A's office. Staff D heard this while sitting at a table in the dining room approximately 75 feet away.</p> <p>On 3/5/18 Staff F reported seeing Staff A pull Tenant #9 into a sitting position on the bed. Staff A then pulled Tenant #9 out of the bed and placed the tenant into a wheelchair. Staff F stated Tenant #9 was able to walk but Staff A did not wait for Tenant #9 to put his/her feet on the</p>	A 012	<p>The program will ensure that all tenants are treated with respect and dignity. Tenants will be allowed to refuse services at any time. All staff are given a copy of tenant rights upon hire. The Health Services Director will go over tenant rights again with all staff at the next staff inservice on 6/10/18.</p>	

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A 012	<p>Continued From page 2</p> <p>ground before the transfer occurred. Tenant #9 was upset as he/she wanted to remain in bed. Staff F stated Tenant #2 told her about Staff A pulling him/her out of bed by the arms.</p> <p>On 3/1/18 at 10:40 AM Staff H reported entering Tenant #2's apartment shortly after Staff A had been there. Tenant #2 was upset and reported Staff A had picked him/her up and his/her legs were dangling in the air.</p> <p>On 4/9/18 at 1:55 PM Staff L reported attending a tenant meeting with Staff A. Staff A raised her voice at a tenant when the tenant started revealing personal information. Staff L said Staff A did apologize to the tenant.</p> <p>On 4/7/18 at 10:15 AM Staff U (a former employee) reported Tenant #5 did not like to bathe. Tenant #5 lived on the memory care unit. Staff U was in Tenant #5's apartment with Staff A when Staff A stated Tenant #5 needed a bath. Staff U reported Staff A forcibly removed Tenant #5's pants while Tenant #5 hit at Staff A. Staff A told Tenant #5, "You need to shower, you stink." Staff U reported the more Tenant #5 fought Staff A, the more Staff A manhandled the tenant. Staff A pulled up Tenant #5's shirt while Tenant #5 pulled it down. Staff U said Staff A finally took Tenant #5's shirt off. Tenant #5 then slapped Staff A.</p> <p>On 4/18/18 at 1:30 PM Tenant #11 reported Staff A was rough and in a hurry when she dressed him/her. Tenant #11 said Staff A pulled on his/her arm to get him/her to move more quickly. Tenant #11 stated Staff A couldn't help it, it was just her way.</p>	A 012		

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A 012	Continued From page 3 Staff A denied taking part in these incidents or having knowledge of them during an interview on 3/6/18 at 10:30 AM. 2. Other incidents reported included: On 4/9/18 at 5:50 PM Staff O reported hearing Staff K berate Tenant #12. Tenant #12 was 98 years old, diagnosed with dementia and had a history of falls. Tenant #12 was told to get dressed on their own when Tenant #12 was physically and cognitively unable to do so. Staff O reported hearing Staff K tell Tenant #12 to sit on the toilet until he/she was finished. Tenant #12 got off of the toilet and was found by Staff B and Staff O in bed with feces on his/her hands. On 4/16/18 at 3:25 PM Staff V reporting hearing Staff K repeatedly tell Tenant #5 to "Get out" of an apartment the tenant thought they lived in. Tenant #5 was diagnosed with dementia and was confused at the time. On 3/6/18 at 8:45 AM Tenant #10 reported being showered by former Staff W. The tenant believed Staff W was angry because Tenant #10 had pushed his/her pendant too many times. Tenant #10 reported being screamed at by Staff W "for a while." Tenant #10 stated he/she was afraid during this event.	A 012		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance	A 089		

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A 089	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenant's needs were addressed in service plans for 4 of 13 tenants reviewed. Findings follow:</p> <ol style="list-style-type: none"> 1. Record review revealed Tenant #5 was admitted to the memory care unit of the program on 10/5/17. Further review revealed the following: <ol style="list-style-type: none"> a. The most recent service plan dated 1/2/18 identified Tenant #5 required standby assistance twice weekly with showers to assure resident safety. The plan identified Tenant #5 had issues with depression which would be monitored by staff. b. A nurse review conducted on 4/3/18 documented, "Resident is assist with bathing. Staff has had issues with this in the past and we are progressing forward with changes in medication and approaching resident with use of re-direction and different staff to accomplish this task." c. A review of program task sheets revealed Tenant #5 had one shower completed in the month of March. One shower was completed during the time period of 4/1/18 to 4/10/18. d. During an interview on 3/5/18 at 12:50 pm, the Health Services Director reported she was aware Tenant #5 did not like bathing or changing clothing and would sometimes slap caregivers. e. During an interview on 3/5/18 at 12:20 pm, Staff C reported Tenant #5 hit, punched and kicked when caregivers tried to give Tenant #5 a shower. 	A 089	<p>A new Health Services Director was hired on 4/30/18 and trained on how to properly do a service plan by our Quality control nurse on 5/15 and 5/16 and then trained by our corporate education nurse 5/22 and 5/23. All service plans will adhere to each residents individual needs.</p>	

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A 089	<p>Continued From page 5</p> <p>f. During an interview on 3/5/18 at 11:10 am, Staff E reported Tenant #5 sometime refused cleaning below the waist and often went days without a shower.</p> <p>g. During an interview on 4/17/18 at 10:15 am, former Staff U reported Tenant #5 hit staff if they attempted to bathe him/her. Tenant #5 wore the same clothes for 2 weeks at a time.</p> <p>h. During an interview on 4/17/18 at 10:50 am, former Staff Y reported it was difficult to undress Tenant #5 for a shower and described incidents when Tenant #5 moved from seat to seat with feces soiled clothing.</p> <p>i. These needs were not addressed on the service plan.</p> <p>2. Record review revealed Tenant #9 was admitted to the program on 6/4/16 and currently resided on the memory care unit. Further review revealed the following:</p> <p>a. A service plan dated 1/8/18 identified Tenant #9 required assistance with bathing 2 times weekly.</p> <p>b. A review of program task sheets revealed Tenant #9 had no showers completed during the month of March and one shower completed during the time period of 4/1/18 to 4/7/18.</p> <p>c. During an interview on 4/17/18, Staff K reported Tenant #9 had grabbed her hand, twisted it and kicked her in the stomach when she attempted to help Tenant #9 get dressed. Staff K reported another incident in which Tenant #9 had yelled and thrown something at her when she tried to help change Tenant #9's clothing.</p> <p>d. During an interview on 4/16/18 at 3:45 pm, Staff S reported it was difficult to get Tenant #9 to take a bath.</p> <p>e. During an interview on 4/17/18 at 10:50 am, former Staff Y reported Tenant #9 did not like to</p>	A 089		

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A 089	<p>Continued From page 6</p> <p>bathe or change clothing.</p> <p>f. During an interview on 4/18/18 at 2:40 pm, former Staff Z reported Tenant #9 had kicked her in the stomach and rammed her walker into another caregiver. Staff Z stated Tenant #9 did not like to shower.</p> <p>g. These needs were not addressed on the service plan.</p> <p>3. Record review revealed Tenant #12 was admitted to the program on 11/16/17 and currently resided on the memory care unit. Further review revealed the following:</p> <p>a. A service plan dated 2/4/18 identified Tenant #12 was independent with ambulation and transferred with the use of a wheeled walker. The service plan identified Tenant #12 was independent with bathroom use with some reminders. The tenant required assistance with dressing in the morning.</p> <p>b. A review of incident reports revealed Tenant #12 had falls on the following dates: 3/9/18, 3/11/18, 3/18/18 and 3/29/18. b</p> <p>c. An-office note dated 4/9/18 stated Tenant #12 was "going to have a fall with serious injury unless [his/her] environment is modified."</p> <p>d. During an interview on 4/10/18 at 2:35 pm, the Health Services Director stated she believed Tenant #12 needed assistance with dressing following toileting due to cognitive limitations and being a fall risk.</p> <p>e. During an interview on 4/12/18 at 11:20 am, Staff C reported Tenant #12 needed guidance to dress as the tenant's knees often gave out. Staff C felt it was not safe to leave Tenant #12 on the toilet and expect the tenant to dress his/her lower body without staff assistance.</p> <p>f. These needs were not addressed on the service plan.</p>	A 089		

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A 089	<p>Continued From page 7</p> <p>4. Record review revealed Tenant #13 was admitted to the program on 10/6/12. Tenant #13 was hospitalized from 7/6/17 to 7/9/17 for hypertensive urgency. Further review revealed the following:</p> <ul style="list-style-type: none"> a. An updated service plan was created on 7/19/17. A health evaluation completed at the same time identified Tenant #13 reported feeling weak and having pain everywhere. According to the service plan, Tenant #13 was independent with ambulation and transfers. b. A review of 24 hour report logs revealed caregivers had documented Tenant #13 needed assistance ambulating to and from the bathroom on 7/16/17, 7/17/17, 7/18/17, 7/20/18, 7/21/17 and 7/26/17, using descriptors such as: wobbly, very weak, hard to walk, very unsteady, could not stand without help and can't use left arm - total assist. c. A review of incident reports revealed Tenant #13 had two falls on 7/16/17 which resulted in a visit to the Emergency Room for a single contusion with soft tissue hematoma to the left buttocks and left elbow. d. Nursing notes revealed Tenant #13 received an order from his/her prescription to use a sling as needed for the left elbow pain. e. These needs were not addressed on the service plan. <p>An interview with the Health Services Director on 4/19/18 at 11:40 PM confirmed these findings.</p>	A 089		
D103	<p>481--52.2(2)a Reporting Suspected Dependent Adult Abuse</p> <p>52.2(2) Reporting suspected dependent adult abuse in facilities or programs.</p>	D103		

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D103	<p>Continued From page 8</p> <p>a. If a staff member or employee is required to make a report pursuant to this rule, 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 24 hours of such notification or the next business day.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to report an allegation of suspected dependent adult abuse to the Department as required. Findings include:</p> <p>During an interview on 4/10/18 at 2:35 PM, the Health Services Director reported hearing Staff K berate Tenant #12 two times on 4/5/18. She stated she reported these incidents to the Executive Director on 4/5/18.</p> <p>When interviewed on 4/10/18 at 12:30 PM, Staff O reported she entered Tenant #12's apartment on 4/5/18 at approximately 1:00 PM and saw both the tenant and Staff K in the bathroom. Tenant #12 was crying as Staff K yelled at him/her to stay on the toilet until finished as well as telling the tenant he/she had hurt her (Staff K's) back. Staff O described the incident as "the worst thing she had ever seen." Staff O reported the incident to the Executive Director on 4/6/18. Staff O reported the Executive Director responded, "I don't have time for that. I have to work the floor." Staff O reapproached the Executive Director with her concerns on 4/9/18.</p>	D103	<p>Any suspected abuse will be reported to the department within the first 24 hours. All staff have been retrained on what to do and whom to notify if they suspect abuse. Staff have also been made aware of the employee hotline and the 800 number for the department if they do not feel comfortable reporting to their immediate supervisor. Staff were retrained at the inservice on 4/25/18.</p>	

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D103	<p>Continued From page 9</p> <p>On 4/17/18 at 11:50 AM, the Executive Director confirmed she had been made aware of the situation involving Staff K and Tenant #12 on 4/5/18, 4/6/18 and 4/9/18. The Executive Director stated she believed Staff K was acting in an emotional manner due to back pain but that her intentions were not malicious. For this reason, she did not report the suspected mistreatment to the Department.</p> <p>During an interview on 4/12/18 at 10:55 AM the Marketing and Operations Specialist confirmed these concerns were not properly reported and reported the incident to the Department herself.</p>	D103		
D104	<p>481--52.2(2)b Reporting suspected Dependent Adult Abuse</p> <p>52.2(2) Reporting suspected dependent adult abuse in facilities or programs.</p> <p>b. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within 24 hours or the next business day.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, Program staff failed to report suspected dependent adult abuse to the Department as required. Findings follow:</p> <p>An interview conducted with Staff C on 3/5/18 at 12:20 PM revealed she believed Tenant #2 had been abused. Staff C said Tenant #2 had reported being picked up out of bed by Staff A</p>	D104		

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D104	<p>Continued From page 10</p> <p>(the former Executive Director) with his/her legs dangling. Staff C did not report this suspected abuse to the Department.</p> <p>An interview conducted with Staff D on 3/5/18 at 10:32 AM revealed she believed Tenant #2 had been abused. Staff D recounted an incident in which Tenant #2 reported being pulled out of bed and "manhandled" by Staff A. Staff D did not report this suspected abuse to the Department.</p> <p>An interview conducted with Staff F on 3/5/18 revealed she believed tenants at the program had been abused. Staff F reported being told by Tenant #2 that Staff A had pulled him/her out of bed by the arms leaving his/her feet dangling. Staff F did not report any suspected abuse to the Department.</p> <p>An interview conducted with Staff U on 4/17/18 at 10:15 AM revealed she observed an event she considered to be abusive. Staff U was in Tenant #5's apartment when Staff A forcibly undressed Tenant #5 in order to give him/her a bath. Staff U stated Tenant #5 had refused to bathe for many days. Staff U reported Staff A pulled down Tenant #5's pants while Tenant #5 was pushing the staff's hands away. Staff A then removed Tenant #5's shirt when Tenant #5 kept trying to pull the shirt down. Staff U did not report this suspected abuse to the Department.</p> <p>During an interview on 4/25/18 at 9:00 AM, the Marketing and Operations Specialist confirmed these concerns were not properly reported.</p>	D104		