

DEPARTMENT OF INSPECTIONS AND APPEALS

✓ 1/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0288	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/12/2018
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NAME OF PROVIDER OR SUPPLIER SUNNYBROOK OF MUSCATINE	STREET ADDRESS, CITY, STATE, ZIP CODE 3515 DIANA QUEEN DRIVE MUSCATINE, IA 52761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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: 52 Number of tenants with cognitive disorder: 3</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 11</p> <p>Total Census of Assisted Living Program for People with Dementia: 66</p> <p>No regulatory insufficiencies were cited regarding the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.</p> <p>The following regulatory insufficiency was identified during the investigation of Incident 79682-I:</p>	A 000	<p>All staff have been re-delegated by the RN on gait belt, transfers, and safety precautions with transferring a resident with a wheeled walker as of 11-14-2018. All new hires will have delegation for gait belt use prior to being scheduled to work independently with residents and program will continue to offer in- services and trainings as needed. Those residents requiring gait belt use are identified in the resident's Service Plan as well as medication cabinet within each residents apartment.</p> <p>Our program has already completed he Plan of correction.</p>	
A 013	<p>481-67.3(2) Tenant Rights</p> <p>481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.</p>	A 013		

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

TITLE

(X6) DATE

✓ 1/28/19

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 013	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure appropriate cares were provided for 1 of 1 tenants identified in self-reported incident 79682-I (Tenant #1) . Finding follows:</p> <p>Record review on 12/11/18 revealed an incident report dated 10/30/18 describing an incident when Tenant #1 went to sit down and the walker "got away" from her and she fell forward hitting her head on the floor.</p> <p>When interviewed on 12/11/18 at 10:05 a.m. the Health Services Coordinator (HSC) stated Staff A had failed to use a gait belt with Tenant #1 as indicated in the service plan. The HSC explained Staff A had been disciplined and all staff received training/retraining on using a gait belt with Tenant #1.</p> <p>When interviewed on 12/11/18 at 10:30 a.m. Staff A admitted she should have used a gait belt but there wasn't one in the room. She said she was assisting Tenant #1 to sit down when she fell.</p> <p>Record review on 12/11/18 revealed notes regarding the incident indicating on 10/30/18 at 2:00 p.m. the nurse was notified that Tenant #1 was on the floor after a witnessed fall. On evaluation, Tenant #1 had a head laceration. After vitals were taken and were within normal limits staff applied a compress to the head wound. According to the note Tenant #1 was</p>	A 013		

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A 013	<p>Continued From page 2</p> <p>oriented when asked what happened. Due to the laceration and blood on the head Program staff called 911 who transferred Tenant #1 to the local Emergency Room (ER). The ER reported they would obtain a computed topography (CT). The CT showed no bone separation and the tenant received 20 sutures. She was admitted to the hospital for observation. Review of the hospital's History and Physical on 12/12/18 revealed Tenant #1 sustained a complex 15.5 centimeter laceration of her left scalp with underlying hematoma and exposed blood vessel. She was seen by general surgery and received 20 stitches to her laceration. Laboratory data indicated a drop in hemoglobin for 10.1 to 7.8. Tenant #1 was admitted for observation due to the significant trauma she sustained to her head. According to the physician's note, at the center of the wound was a large pumping blood vessel which had stopped pumping but was left alone. Any manipulation of this would potentially cause severe bleeding as it had been lightly manipulated by the physician before the procedure and there was a fair amount of blood coming from it at a trajectory that was significant. Further review revealed the physician was able to control this prior to the procedure. An additional note from the physician said, "The laceration had somewhat of a complex nature and that it was not straight, and had noted exposed blood vessel making closure somewhat treacherous at times."</p> <p>Further review of the charting notes revealed when interviewed by the Program, Staff A admitted she failed to lock the brakes on Tenant #1's walker or utilize a gait belt.</p> <p>Review of Tenant #1's service plan dated 9/25/18</p>	A 013		

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A 013	Continued From page 3 on 12/12/18 revealed the service plan directed staff to utilize a gait belt during transfer. During her interview Staff A admitted she did not use the gait belt as directed by Tenant #1's service plan.	A 013			