Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: June 25, 2018
Program Name: Sunnybrook of Muscatine
Address: 3515 Diana Queen Drive Muscatine, IA 50288
Type of Action: Investigation #75632-I
Date(s) of Action: June 6 -7, 2018

State Rule #	State Rule	Amount of Civil Penalty
69.29(3)	**481-69.29(231C) Staffing.** **69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population**. Based on interview and record review the Program failed to ensure staff received appropriate training for assigned tasks and target population. This pertained to 1 of 1 tenant (Tenant #1) that experienced major injury. Finding follows: Record review revealed Tenant #1's Service Plan, dated 3-31-18, noted he/she required assistance of one staff for ambulation and transfers. He/she began to use a wheelchair and would propel himself/herself at times. The Service Plan indicated he/she lacked the ability to understand safety concerns and attempted to ambulate independently at times. Continued record review revealed Tenant #1's Global Deterioration Scale (GDS) dated 3-31-18 revealed a score of five (5) and indicated severe cognitive decline. Review of Tenant #1's Charting Notes dated 4-5-18 revealed a late chart for quarterly assessment, completed 3-31-18, indicated he/she required assistance with toileting, dressing, bathing, grooming, medications, and required assist of one with transfers and ambulation. The assessment noted he/she used wheelchair and propelled himself/herself at times. Review of Incident Report and Investigation Worksheet dated 4-30-18 indicated Tenant #1 self-propelled himself/herself over a curb and fell face first on the concrete. The fall resulted in skin tears and bleeding. The staff called 911 and he/she was transported to the hospital for treatment. Continued record review revealed a lack of staff training regarding wheelchair use and safety for the tenants residing at the Program. When interviewed on 6-7-18 at 9:08 a.m. the Director stated she took two tenants outside on 4-30-18 to enjoy the nice weather. She	**$1000.00**

	walked along the sidewalk pushing Tenant #1 in his/her wheelchair and another tenant walked behind them pushing a cart. She stated the other tenant got stuck on a crack in the sidewalk. She turned to assist the other tenant and when she turned back to Tenant #1 he/she propelled himself/herself over a curb and fell face first onto the concrete. His/her glasses were broken and he/she bled from the nose. Another staff witnessed fall, but was unable to reach Tenant #1 in time. The Director stated she was about three steps away from Tenant #1 and did not think he/she would propel himself/herself. The Director notified family. When the Director visited the hospital she was informed Tenant #1 had numerous skin tears and a fractured nose. The Director stated she knew Tenant #1 had the ability to propel himself/herself in the wheelchair and just did not think to lock the wheels prior to leaving him/her unattended. The Director stated she received no training for wheelchair use and safety. She stated they completed a training to all staff after the incident and now have included this as part of the nurse delegation training.	