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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
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: 44 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 46 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 61 A recertification visit was conducted to determine compliance with certification for an Assisted Living Program. In addition to the recertification visit, Complaint #64181-C and Complaint #64938-C were investigated. The following regulatory insufficiencies were identified:	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	All management will follow all policies and procedures for program.	2/13/17

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 003	Continued From page 1	A 003		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the Program failed to follow policies and procedures regarding narcotics for 3 of 8 tenant files reviewed (Tenants #6, #7 and #8). In addition, the Program failed to follow the policy regarding reporting suspected dependent adult abuse. Findings follow:

Review of Tenant #6's file revealed the service plan dated 9-17-16 indicated staff administered the tenant ' s medications. Tenant #6 had an order dated 9-26-16 for Tramadol 50 milligram (mg) tablet, one tablet four times per day. The October 2016 medication administration record (MAR) indicated from 10-1-16 to 10-31-16 there were 18 times Tramadol was documented as not given. The entries were initialed and circled by staff and explanations for the medication not given as ordered included: out of the program, withheld per doctor/nurse orders, tenant refused and not available from pharmacy. The MARs indicated Tramadol was a controlled substance however there were no narcotic count sheets for Tenant #6 as required by policy prior to 10-28-16.

Review of Tenant #7's file revealed the service plan dated 10-5-16 indicated staff administered his/her medication. Tenant #7 had an order for Alprazolam 0.25 mg twice daily as needed. According to a Narcotic Inventory Count sheet on 10-14-16, 23 tablets of Alprazolam were destroyed with none remaining. The destruction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0287	A. BUILDING _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 003	Continued From page 2 of the medication was not recorded on the medication destruction record, per the Program's policy and procedure. Review of Tenant #8's file revealed the service plan dated 10-31-16 indicated staff administered his/her medication. Record review indicated Tenant #8 had an order dated 9-28-16 for Tramadol 50 mg, one tablet every four hours as needed for pain for seven days. The script indicated 42 tablets were supplied to the Program. The medication was started on 9-30-16 and discontinued on 10-8-16. A review of MARs revealed 12 doses were documented as administered between 10-3-16 to 10-7-16. The MARs indicated Tramadol was a controlled substance however no narcotic sheets for the time period it was ordered were completed as required by the Program's policy and procedure. Once the medication was discontinued on 10-8-16 the pill bottle remained in Staff G's office until it was found by the Regional Nurse on either 10-24-15 or 10-25-16. The medication was not destroyed as required per the Program's policy and procedure. Interviews with the Regional Nurse on 1-5-17, 1-9-17 at 5:15 p.m. and 1-10-17 at 12:47 p.m. indicated Staff G was terminated regarding a bottle of Tramadol found in her desk. The Tramadol for Tenant #8 was discontinued on 10-7-16. The bottle in the desk contained 18 or 19 pills less that it should based on documentation on the MARs. The remaining Tramadol in the bottle were destroyed; however, the destruction record could not be found. The Regional Nurse said if a controlled substance was not administered as ordered it could not be returned to pharmacy and needed to be	A 003		

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
	S0287	A. BUILDING _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 003	Continued From page 3 destroyed. According to the Program's policy and procedure regarding narcotic count, the medication aides/licensed nurse were to utilize a 2 person count procedure at the beginning and end of each shift. In addition, the Program had a policy that all discontinued, expired and unused medications were to be destroyed. Destroyed narcotics were to be documented on a written narcotic disposal form. According to the Program's policy and procedure regarding dependent adult abuse reporting and training, all employees determined to be mandatory reporters were required to notify the Department within 24 hours of any concerns related to abuse, neglect, or misappropriation of tenant belongings. See RI under 52.2(2)a.	A 003		
A 013	481-67.3(2) Tenant Rights 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. This REQUIREMENT is not met as evidenced by: Based on record review and tenant interviews the Program failed to provide care, treatment and services which were adequate and appropriate for 3 of 8 tenants reviewed (Tenants #1, #2 and #6). Findings follow: 1. Review of Tenant #1's file revealed diagnoses	A 013		

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
	S0287	A. BUILDING. _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 013	Continued From page 4 including sleep apnea, chronic obstructive pulmonary disease and pulmonary embolism. According to a Pulmonology Office/Clinic Note dated 7-7-16 Tenant #1 used a continuous positive airway pressure machine (CPAP) at night with oxygen. Interview with Tenant #1 on 1-5-17 revealed staff did not know how to help with the CPAP tubing when the tenant needed assistance. The tenant's family resolved the issue. Review of Nurse Delegation revealed that Staff B, C, E, and F received training for oxygen and CPAP needs. Further review of Tenant #'1 file revealed an order for Tramadol tablet, 50 mg four times daily as needed for pain. The tenant stated when he/she requested a pain pill, he/she had to wait for two staff to come administer the medication. The wait in the evening could take up to, but no more than, an hour. 2. Review of Tenant #2's file revealed the service plan dated 12-5-16 indicated the tenant was blind. Room trays were delivered to Tenant #2's apartment and dietary allergies of yeast and fermented products were listed. Tenant #2 stated during interview on 1-5-16 at 12:40 p.m. that the evening before when the room tray arrived, he/she asked staff what the meal was but staff did not say bread was included in the main entree. Tenant #2 stated he/she had not had a bread product in several years and due to lack of vision could not identify items on the tray. Tenant #2 stated he/she consumed the food (which contained bread product) and then was terribly sick throughout the night. 3. Record review of Tenant #6's file revealed Charting Notes dated 11-11-16 indicated physical	A 013	The program will have an outside source come and provide training for all caregivers on the CPAP machine. The program will have the Dining Services Director make the menu each week with anything that has yeast in it and it will be up to the cook to take the order and remind resident of ingriedients. The ISP will be updatedshowing that the resident has been educated on her allergy.	3/1/17 3/1/17

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 013	Continued From page 5 therapy (PT) wanted staff to walk Tenant #6 to meals twice per day with a wheeled walker, followed by a wheelchair. Charting Notes dated 11-20-16 indicated Tenant #6 required assistance of one for transfers and ambulation with a wheeled walker. Staff walked Tenant #6 to meals with a wheeled walker and wheelchair following twice daily per PT. The service plan dated 11-20-16 indicated staff walked Tenant #6 to meals with a wheeled walker twice per day. Interview with Tenant #6 on 1-5-17 at 12:55 p.m. revealed although he/she was to be walked to meals twice per day, it had not occurred for six weeks. Tenant #6 said he/she would like staff to assist him/her with walking to meals.	A 013	The HSD and RCC will monitor that staff are reading, signing, and doing what is expected of them per the service plans. A service plan binder has been made and put in the caregiver's office where the HSD will put updated service plans for them to read and sign.	2/13/17
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants ' identified needs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and a community meeting the Program failed to provide a sufficient number of trained staff to meet the needs of 3 of 5 tenants whose personal emergency response system records were reviewed (Tenants #4, #6 and #9). Findings follow: A community meeting was held on 1-3-17 at 2:30 p.m., with 18 tenants and 3 family members. Several tenants and one family member stated that when they pushed the pendant for staff	A 055	With a new RCC on board she knows that she will need to monitor the pendant system on a weekly basis by printing reports and finding out if pendants have not be answered in a timely manner.	2/13/17

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 055	Continued From page 6 assistance, it could take up to one hour for staff to respond. Review of personal emergency response records from 12-1-16 to 1-10-17 for Tenant #4 revealed 13 times that staff response was greater than 15 minutes, including 3 times when the response time was greater than 30 minutes. Review of personal emergency response records from 12-1-16 to 1-10-17 for Tenant #6 revealed 2 times when the staff response was greater than 15 minutes including 1 time when the response time was greater than 50 minutes. Review of personal emergency response records from 12-1-16 to 1-10-17 for Tenant #9 revealed 3 times when the staff response was greater than 15 minutes. An interview with the Regional Nurse on 1-10-17 at 12:47 p.m. revealed the policy for the pendant response was five minutes. She confirmed some calls for assistance on evening and nights exceeded the timeframe. Record review revealed the Program's policy regarding personal response system indicated staff were to respond to pages within five minutes.	A 055		
A 060	481-67.9(4)c Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:	A 060		

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
	S0287	A. BUILDING. _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 060	Continued From page 7 c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide Registered Nurse (RN) delegation training for activities of daily living (ADLs) for 3 of 3 non-certified staff (Staff A, B and F). Findings follow: A community meeting was held on 1-3-17 at 2:30 p.m., which included 18 tenants and 3 family members. Several tenants made comments they felt staff was not properly trained to provide the needed services they required and family members agreed that some staff did not seem to be properly trained to provide cares. Review of Staff A's file revealed a hire date of 11-14-16. No RN delegation training regarding ADLs could be located. Review of Staff B's file revealed a hire date of 11-30-15. The employee received initial RN delegations training, including ADLs, in December 2015 within 30 days of Staff B's employment. Subsequent RN delegations were completed on 10-7-16, by the former RN (within 60 days of her employment); however, did not include any training or review regarding ADLs. Review of Staff F's file revealed a hire date of 11-1-16. RN delgation training was received on 10-26-16; however, the training did not include	A 060	All new hire caregivers will be delegated by the RN within 30 days of hire. New HSD will be trained that caregivers must be delegated after their 2 week training period before they can work a shift by themselves. The ED will ensure that this is being done during her Q/A process. This will be completely immediately following the RN's start date on 2/27/17.	

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 060	Continued From page 8 ADLs. Interview with Interim Executive Director on 1-4-17 at 4:57 p.m. confirmed Staff A, B, and F were all non-certified.	A 060	All doctor orders will be followed. The HSD and RCC will monitor daily that meds are being given and if there is a missing med the RN will be notified immediately.	2/13/17
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to administer medications as ordered for 2 of 8 tenants reviewed (Tenants #6 and #7). Findings follow: 1. Record review of Tenant #6's file revealed the service plan dated 9-17-16 indicated staff administered Tenant #6's medications. Tenant #6 had an order for Tramadol 50 milligram (mg) tablet, one tablet four times per day dated 9-26-16. The times the medication was to be administered were as follows: 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. The October 2016 medication administration record (MAR) indicated from 10-1-16 to 10-31-16 there were 18 times Tramadol was documented as not given. The entries were initialed and circled by staff and explanations for the medication not given as	A 147		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 147	Continued From page 9 ordered included: out of the program, withheld per doctor/nurse orders, tenant refused and not available from pharmacy. There were no orders or documentation found for a doctor or nurse hold as indicated in the exception charting. In addition, it was documented the medication was unavailable from pharmacy for the 8:00 p.m. dose on 10-21-16 and for the 8:00 a.m. dose on 10-22-16; however, the medication was available and documented as given for the three other scheduled doses on 10-21-16 and 10-22-16. The script indicated 120 tablets were to be dispensed/supplied dated 9-26-16, which was a 30 day supply at 4 times per day. There was no indication additional Tramadol were sent by the pharmacy on 10-22-16. 2. Record review of Tenant #7's file revealed between 4-4-16 and 11-1-16, the tenant was to have received one tab Temazepam 7.5 mg at bedtime. Review of July, August, September and October 2016 MARs indicated the medication was routinely documented as not administered.	A 147		
A 149	481-67.9(6) Staffing 481-67.9(231B,231C,231D) Staffing. (6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 2 staff completed two hours of training required for the identification and reporting of dependent adult abuse within six	A 149	All new employees will receive Dependant Adult Abuse training within their first 6 months of hire. This will be the RCC's job to monitor with our training schedule online. They will ensure immediately that it gets completed and that anyone whom needs renewal after 5 years receives that as well.	2/13/17

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
	S0287	A. BUILDING. _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 149	Continued From page 10 months of employment as required by Chapter 235B. Findings include: Chapter 235 B requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every five years using an approved curriculum. Review of Staff B's file revealed a hire date of 11-30-15. The staff completed Dependent Adult Abuse training on 8-5-16, which was longer than six months from the time of employment. Interview with Interim Executive Director on 1-4-17 at 4:57 p.m. revealed no other documentation of Dependent Adult Abuse training could be provided for Staff B.	A 149		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.	A 037		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 037	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the Program failed to evaluate each tenants' functional, cognitive and health status as required for 8 of 8 tenants reviewed (Tenants #1, #2, #3, #4, #5, #6, #7 and #8). Findings follow: 1. Review of Tenant #1's file revealed an admission date of 10-1-14. A nurse review was completed 7-27-16 but no subsequent entries indicating annual evaluations were found. A service plan was completed on 10-27-16; however no evaluations were completed. Cognitive, health and functional evaluations were not completed annually. 2. Review of Tenant #2's file revealed an admission date of 7-1-14. Nurse reviews dated 6-3-16 and 9-1-16 included an evaluation of health status and functional abilities; however, a cognitive evaluation was not completed at either interval. A cognitive evaluation was not completed annually. 3. Review of Tenant #3's file revealed an admission date of 10-7-15. Evaluations were completed within 30 days on 11-6-15. Charting Notes dated 10-17-16 indicated an evaluation of health status was completed; however, functional and cognitive evaluations were not included. Functional and cognitive evaluations were not completed annually. 4. Review of Tenant #4's file revealed an admission date of 6-19-14. Nurse reviews dated 6-10-16 and 9-7-16 included an evaluation of	A 037	Assessments will be done by the RN for intial 30 day, change of condition, quarterly, and annually. They will include the safety evaluation, fall assessment, self medication, DOARS, elopment, and health and functional assessment. The RN will keep track in our SPA program when each assessment is due. All residents are to have their evaluation paperwork, initial, 30 day, change of condition and annual assessments in their charts. The RN will ensure this is all in their chart with the ED and regional nurse checking during the Q/A.	2/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0287	A. BUILDING _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 037	Continued From page 12 health status and functional abilities; however, a cognitive evaluation was not completed at either interval. A cognitive evaluation was not completed annually. 5. Review of Tenant #5's file revealed an admission date of 8-16-16. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 6. Review of Tenant #6's file revealed an admission date of 8-20-16. Cognitive, health and functional evaluations were not completed within 30 days of taking occupancy. 7. Record review of Tenant #7's file revealed diagnoses including dementia and a GDS score of 6 which indicated severe cognitive decline. Tenant #7 resided in the dementia unit. Change of condition evaluations were completed on 3-1-16. No other evaluations were completed with the exception of a 90 day nurse review on 6-26-16 and a 90 day nurse review on 12-22-16 which was not comprehensive regarding Tenant #7's health status. Program documentation including MARs and Monthly Vital Signs sheets indicated the tenant lost 40.4 pounds from July to November 2016. Twenty-four hour report sheets revealed the following: a. On 12-25-16 Tenant #7 had a bowel movement (BM) mess and was changed in bed. He/she refused to get out of bed or take morning medications. The tenant was aggressive. The sheets were wet and soiled and family requested every piece of bedding be washed. b. On 12-26-16, 12-28-16 and 12-29-16 Tenant #7's protective undergarment was changed in bed. Tenant was very aggressive while changing. On 12-28-16 Tenant #7's bedding was soaked all the way down to the	A 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0287	A. BUILDING _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 037	Continued From page 13 mattress. c. On 12-30-16 Tenant #7 was constipated and finally had a hard BM. Tenant #7 was a two person assist. He/she was very aggressive, yelling, swearing, pinching and swinging arms. d. On 1-1-17 Tenant #7 was a two person assist. He/she was aggressive while changing in bed, kicking, swearing and trying to hit staff. e. On 1-3-17 Tenant #7 was changed in bed with two person assist and was aggressive. Tenant #7 had a BM and it was "stuck." f. On 1-5-17 Tenant #7 was very difficult to transfer at bedtime. Tenant #7 was very aggressive which resulted in a skin tear on the right hand. Charting Notes indicated the following: a. On 10-31-16 Tenant #7 had a 13 centimeter (cm) by 10 cm bruise noted on the back of the left hand, and a 2 cm by 1 cm skin tear noted to the left elbow. Triple antibiotic ointment (TAO) and a band aid were applied. b. On 12-22-16 Tenant #7 had a reddened groin area. Staff used Nystatin to clear it up. c. On 1-6-17 a skin tear was found by day staff on Tenant #7's right hand. The hand was cleansed and dressed with TAO and wrapped with a conforming gauze bandage. Evaluations were not completed as needed with significant change including incontinence resulting in soiled bedding, weight loss, difficulty with BMs, changing Tenant #7's protective undergarment in bed with two staff, the routine nature of Tenant #7's behaviors, the reddened area with Nystatin treatment and fragile skin with proneness to skin tears. 8. Review of Tenant #8's file revealed an admission date of 10-23-15. Charting Notes	A 037		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 037	Continued From page 14 dated 10-31-16 included an evaluation of health status and functional abilities. A cognitive evaluation was not completed. Interview with the Interim Executive Director on 1-4-17 at 11:48 a.m. stated the former nurse had not completed evaluations since electronic charting was started in September 2016. Interview with the Regional Nurse on 1-10-17 at 12:47 p.m. indicated that additional documentation of functional, cognitive and health assessment could not be found for any of the listed tenants.	A 037		
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 record review and staff interview service plans were not developed based on evaluations/assessments and/or updated as needed for 8 of 8 tenants reviewed (Tenants #1, #2, #3, #4, #5, #6, #7 and #8). Findings follow: 1. Review of Tenant #1's file revealed an	A 083		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 083	Continued From page 15 admission date of 10-1-14. The service plan was updated on 10-27-16. There were no evaluations completed when the service plan was updated. The service plan was not based on evaluations. 2. Review of Tenant #2's file revealed a diagnosis of diabetes. A foot and ankle center clinic note electronically signed on 8-6-16 indicated a recommendation to walk as much as possible throughout the day and for legs to be elevated due to swelling. An orthopedic office clinic note electronically signed on 10-18-16 also indicated a recommendation to walk as much as possible throughout the day and for legs to be elevated due to swelling. The service plan dated 12-5-16 did not include these recommendations therefore did not reflect the service needs of the tenant. 3. Review of Tenant #3's file revealed an admission date of 10-7-15. The service plan was updated on 10-17-16. A nurse review documented in the charting notes on 10-17-16 included a health review that was not comprehensive regarding Tenant #3's health status. Functional and cognitive evaluations were not completed. The service plan was not based on evaluations. 4. Review of Tenant #4's file revealed diagnoses including hypertension, coronary artery disease, osteoarthritis and osteoporosis. Review of a note from the foot and ankle center dated 8-9-16 revealed recommendations for the tenant to keep feet elevated throughout the day, walk as much as possible and consider compression stockings. An orthopedic office clinic note dated 10-18-16 included the same recommendations. The service plans 9-7-16 and 12-13-16 did not include these recommendations therefore did not reflect the service needs of the tenant. 5. Review of Tenant #5's file revealed diagnoses	A 083	Again, it will be the RN's responsibility to ensure that all evaluations and assessements are being done and charted appropriately. The ED and regional nurse will monitor residents charts during Q/A.	2/13/17

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 083	Continued From page 16 including carpal tunnel and osteoporosis. A physician's order was received dated 12-13-16 for a removable splint to be placed on the right elbow at night before bed and removed in the morning after waking. According to a Physician's Orders document dated 12-20-16 there was an order for a right elbow splint and copper gloves to be applied before bed and removed in the a.m. The service plan dated 11-14-16 did not reflect the application and removal of the right elbow arm splint and copper gloves. 6. Review of Tenant #6's file revealed an admission date of 8-20-16. A 30 day service plan was completed dated 9-17-16; however, evaluations were not completed within 30 days. The 30 day service plan was not based on evaluations. In addition, charting notes revealed the following: a. On 9-19-16, Tenant #6 was confident he/she was passing a kidney stone as it had been an ongoing problem all his/her life. b. On 10-5-16 Tenant #6 had discomfort with urination and urinary frequency and an order was received for a urinalysis. c. On 10-10-16 an order was received for an antibiotic. d. On 10-12-16 Tenant #6 was in extreme pain and uncomfortable. The tenant was taken to the ER. e. On 10-13-16 Tenant #6 returned from the ER with a diagnosis of flank pain and hypertension. f. Between 10-6-16 and 12-16-16 Tenant #6 fell or was found on the floor on six times. The service plans dated 9-17-16 and 11-20-16 did not reflect the history of kidney stones, urinary tract infection with antibiotic therapy or falls. The service plan was not updated whenever changes were needed and did not reflect the service needs of Tenant #6.	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 083	Continued From page 17 7. Review of Tenant #7's file revealed diagnoses including dementia and a GDS score of 6 which indicated severe cognitive decline. Tenant #7 resided in the dementia unit. Program documentation including MARs and Monthly Vital Signs sheets indicated the tenant lost 40.4 pounds from July to November 2016. The service plan dated 12-22-16 indicated to continue to provide drink supplements to help with weight gain. The service plan did not reflect Tenant #7 had 40.4 weight loss or other interventions in addition to the supplement. In addition, Program documentation including 24 hour sheets and charting notes revealed incidents regarding bowel movements, aggression towards staff, two person assistance to change the tenant in bed and issues with skin integrity between 10-31-16 and 1-5-17. The service plan dated 12-22-16 reflected Tenant #7 would be clean and dry and would have incontinence garbage removed from the apartment; however did not reflect Tenant #7 ' s difficulty with BMs and related interventions. The service plan did not reflect staff changed Tenant #7's protective undergarment in bed with two staff or the extent of incontinence regarding soiled bedding. The service plan reflected Tenant #7 had occasional periods of agitation; however did not reflect the routine nature of behaviors and related interventions. The service plan reflected Tenant #7 bruised easily related to aspirin therapy but did not reference the reddened area with Nystatin treatment or fragile skin, proneness to skin tears and related interventions. The service plan was not updated when changes were needed and did not reflect the service needs of Tenant #7. 8. Review of Tenant #8's file revealed an admission date of 10-23-15. The service plan was updated on 10-31-16. Charting Notes dated	A 083		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 083	Continued From page 18 10-31-16 indicated heath and functional evaluations were completed in narrative notes; however, a cognitive evaluation was not completed. The service plan was updated however no cognitive evaluation had been completed. Interview with the Regional Nurse on 1-10-17 at 12:47 p.m. confirmed that additional documentation of evaluations or service plans could not be found for any of the listed tenants.	A 083		
A 084	481-69.26(2) Service Plans 481-69.26(231C) Service plans. 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to have preliminary service plans for 2 of 2 tenants reviewed who were admitted in 2016 (Tenants #5 and #6). Findings follow: 1. Review of Tenant #5's file revealed an admission date of 8-16-16. The preliminary service plan dated 8-13-16 was signed by the	A 084	All service plans will be reviewed and signed by the RN, resident and/or POA. Regional nurse will monitor during Q/A that they have been signed by the RN.	2/13/17

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 084	Continued From page 19 former Executive Director and Tenant #5's legal representative. The former Executive Director was not a health care or human service professional. 2. Review of Tenant #6's file revealed an admission date of 8-20-16. The preliminary service plan dated 8-20-16 was signed by the former Executive Director and Tenant #6's legal representative. The former Executive Director was not a health care or human service professional. The Interim Executive Director confirmed in a written statement provided on 1-9-17 at 12:21 p.m. that the former Executive Director was not a health care or human service professional.	A 084	The program will ensure that anyone with a GDS of a 5 or above will have specific activities listed on their service plan. The RN will work closely with the activity director to ensure the appropriate activities are being done.	2/13/17
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to include lists of planned and spontaneous activities based on tenants' abilities and personal	A 092		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 092	Continued From page 20 interests in service plans for 3 of 8 tenants reviewed (Tenants #3, #7 and #8). Findings follow: 1. Review of Tenant #3's file revealed a diagnosis of dementia and a GDS score of 4 which indicated moderate cognitive decline. Tenant #3 resided in the dementia unit. The service plan dated 10-17-16 revealed Tenant #3 was forgetful, needed assistance with decision making and needed reminders throughout the day. The servicee plan indicated the the tenant enjoyed watching television. The service plan did not include any other planned or spontaneous activities based on Tenant #3's personal interest and abilities. 2. Review of Tenant #7's file revealed a diagnosis of dementia and a GDS score of 6 which indicated severe cognitive decline. Tenant #7 resided in the demntia unit. The service plan dated 12-22-16 indicated Tenant #7 was oriented to self only, was redirected by staff and was assisted with decision making. The service plan indicated Tenant #7 enjoyed music activities.The service plan did not reflect any other planned or spontaneous activities based on Tenant #7's personal interests and abilities. 3. Review of Tenant #8's file revealed a diagnosis of dementia and a GDS score of 5 which indicated moderately severe cognitive decline. Tenant #8 resided in the demntia unit The service plan dated 10-31-16 indicated Tenant #8 was oriented to self only, was redirected by staff and was assisted with decision making. The service plan indicated Tenant #8 watched television and (participated in) any activity held. There were no other planned and spontaneous activities listed the service plan. The service plan did not reflect planned and	A 092		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 092	Continued From page 21 spontaneous activities based on Tenant #8's personal interests and abilities.	A 092		
A 096	481-69.27(1)c Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1)c To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; and This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Program failed to assess and document the health status of each tenant at least every 90 days for 3 of 8 tenant files reviewed (Tenants #1, #3 and #7). Findings follow: 1. Review of Tenant #1 file revealed diagnoses including sleep apnea, chronic obstructive pulmonary disease and pulmonary embolism. According to a Pulmonology Office/Clinic Note dated 7-7-16 Tenant #1 used a continuous positive airway pressure machine (CPAP) at night with oxygen. Review of a Physician's Orders document dated 11-2-16 did not indicate	A 096	Nurse reviews should be done with all assessments including initial 30 day, change of condition, quarterly, and annual assessements. RN will ensure that these nurse reviews are being done. Regional nurse will monitor during Q/A.	2/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 096	Continued From page 22 an order for oxygen or a CPAP. A 90 day nurse review was completed 7-27-16 and no subsequent nurse reviews were completed. Nurse reviews were not completed every 90 days for Tenant #1 who received personal and health related care. 2. Review of Tenant #3's file indicated the tenant received personal and health related care. A 90 day nurse review was completed on 7-6-16. Charting Notes dated 10-17-16 indicated a 90 day nurse review was completed. The nurse review documented in Charting Notes dated 10-17-16 was not comprehensive regarding Tenant #3's health status. Nurse reviews were not completed every 90 days for Tenant #3 who received personal and health related care. 3. Review of Tenant #7's file revealed the tenant received personal and health related care. A 90 day nurse review was documented on 6-26-16. There were no subsequent 90 day nurse reviews documented until 12-22-16. The nurse review documented in Charting Notes dated 12-22-16 was not comprehensive regarding Tenant #7's health status. Nurse reviews were not completed every 90 days for Tenant #7 who received personal and health related care. Interview with Interim Executive Director on 1-4-17 at 11:48 a.m. stated the former nurse had not completed reviews since electronic charting was started in September 2016.	A 096		
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an	A 104		

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
	S0287	A. BUILDING. _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 104	Continued From page 23 orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training on sanitation and safe food handling for 2 of 4 staff reviewed (Staff A and C). Findings follow: Staff A had a hire date of 11-14-16 . Review of their employee file revealed no documentation for food safety and sanitation training. Staff C had a hire date of 11-16-16. Review of their employee file revealed no documentation for food safety and sanitation training. Interview with the Interim Executive Director on 1-4-17 at 4:57 p.m. confirmed both Staff A and C served food and that no documentation existed that either had completed any food safety and sanitation training.	A 104	All current employees have taken the food safety training and have proper documentation in files of training. The RCC will monitor food safety training is done with in 30 days of hire and all employees have it yearly They will monitor this in our online training program through SPA. The ED will monitor that the certificates are signed and filed in the staff charts.	2/13/17
A 125	481-69.30(5) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program. This REQUIREMENT is not met as evidenced by:	A 125		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 125	Continued From page 24 Based on record review, staff interviews and family interviews the Program failed to provide dementia-specific training that included hands-on training for 6 of 6 staff files reviewed (Staff A, B, C, D, E and F). Findings follow: 1. Staff A had a hire date of 11-14-16. Review of their employee file revealed no documentation for hands-on dementia training. Staff schedules provided indicated Staff A had assigned shifts in the dementia unit. 2. Staff B had a hire date of 11-30-15. Review of their employee file revealed no documentation for hands-on dementia training. Staff schedules provided indicated Staff B had assigned shifts in the dementia unit. 3. Staff C had a hire date of 11-16-16. .Review of their employee file revealed no documentation for hands-on dementia training. Staff schedules provided indicated Staff C had assigned shifts in the dementia unit. 4. Staff D had a hire date of 6-22-16. Review of their employee file revealed no documentation for hands-on dementia training. Staff schedules provided indicated Staff D had assigned shifts in the dementia unit. 5. Staff E had a hire date of 11-16-16. Review of their employee file revealed no documentation for hands-on dementia training. Staff schedules provided indicated Staff E had assigned shifts in the dementia unit. 6. Staff F had a hire date of 11-1-16. Review of their employee file revealed no documentation for hands-on dementia training. Staff schedules	A 125	The RCC will ensure that 6 hours of class training and 2 hours hands on will be done with all new employees with in 30 days of hire and then yearly there after. They will monitor by putting it into our online training program through SPA. The ED will then ensure that the appropriate certifiates are used and placed in staff files. The certificates will state that there has been 6 hours of class and 2 hours hands on with a total of 8 hours of Dementia specific training. T	2/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
A 125	Continued From page 25 provided indicated Staff F had assigned shifts in the dementia unit. Interview with three family members on 1-3-17 at 3:00 p.m. revealed they felt staff were not trained properly to care for tenants that had dementia. Interview with the Interim Executive Director on 1-4-17 at 4:57 p.m. revealed staff in the general population covered staff breaks in the dementia unit. Interview with the Regional Nurse on 1-9-17 at 2:30 p.m. revealed the schedule was being changed and there were staff that were no longer going to be assigned to work in the dementia unit. The staff reassigned had expressed they did not want to work in the dementia unit. The Regional Nurse observed staff rushing tenants and confirmed the Program needed to get back to basics regarding approach with tenants. Further interview with the Regional Nurse on 1-10-17 at 12:47 p.m. revealed that no documentation was found regarding hands-on dementia training for staff files reviewed. She said hands-on training had occurred in September 2016 with the videos; however, no documentation of the training was available.	A 125	The executive director will ensure a self report is done within 24 hours of notification for any missing narcotics.	2/13/17
D103	481--52.2(2)a Reporting Suspected Dependent Adult Abuse 52.2(2) Reporting suspected dependent adult abuse in facilities or programs. 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	D103		

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
	S0287	A. BUILDING _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
D103	Continued From page 26 agent who shall then notify the department within 24 hours of such notification or the next business day. This Statute 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 within 24 hours or the next business day as required. Findings follow: 1. Record review indicated Tenant #8 had an order dated 9-28-16 for Tramadol 50 milligram (mg), one tablet every four hours as needed for pain for seven days. The script indicated 42 tablets were supplied to the Program. The medication was started on 9-30-16 and discontinued on 10-8-16. A review of Medication Administration Records (MARs) revealed 12 doses were documented as administered between 10-3-16 to 10-7-16. 2. Record review indicated Tenant #11 had an order for Tramadol HCL tablet, 50 mg as needed. 3. According to an Employee Coaching and Counseling Statement, Staff G was suspended pending further investigation due to discovering a discontinued controlled narcotic in her office. 4. Interviews with the Regional Nurse on 1-5-17 and 1-9-17 at 5:15 p.m. indicated Staff G was terminated regarding a bottle of Tramadol for Tenant #8 found in her desk. The Tramadol for Tenant #8 was discontinued on 10-7-16. The bottle in the desk contained 18 or 19 pills less that it should based on documentation on the	D103		

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
	S0287	A. BUILDING: _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

(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
D103	Continued From page 27 MARs. In addition, a bubblepack of Tramadol belonging to Tenant #11 was found hidden in the bookcase. She was not sure how many pills were in the bubbleback. The medications were destroyed after the discovery of the medications; however, a destruction record could not be found. The police were notified and the Regional Nurse instructed the former Executive Director to report the missing medications to the Department; however, it was not done.	D103		