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 11/25/2019

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	Initial Comments 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. General Population Number of tenants without cognitive disorder: 41 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 Total Census of Assisted Living Program for People with Dementia : 50 The following regulatory insufficiencies were cited during the investigation into Complaint #87013-C.	A 000		
A 008	481-67.2(1)e 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. 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.	A 008		

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

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A 008	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete an incident report for an unusual occurrence effecting 1 of 4 tenants (Tenant #4). Findings follow: Record review on 11/20/19 revealed a Charting Note dated 10/24/19 for Resident #4 which made reference to a hanger incident from the previous day. An interview was conducted with the Health Services Director on 11/20/19 at 11:55 AM. She reported Tenant #4 had been suffering from constipation on 10/23/19 and had attempted to alleviate this by inserting a hanger into his anus to dig out the feces. Following this incident, all hangers were removed from his room as a safety precaution. On 11/25/19 at 9:00 AM the Executive Director confirmed an incident report form should have been completed regarding this event.	A 008		
A 061	481-67.9(4)d 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: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives	A 061		

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A 061	Continued From page 2 and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff were competent to meet the needs of tenants and provide training regarding service plan tasks for 1 of 3 tenants reviewed (Tenant #1). Findings follow: Record review on 11/20/19 revealed Tenant #1 had a Resident Service Plan dated 9/19/19. According to the Resident Service Plan, Tenant #1 was incontinent of urine and frequently sat in wet depends for extended period of times. At times, the tenant would use the restroom but would not change her incontinence undergarment if it was soiled. According to the service plan, per the request of Tenant #1's son, the tenant was on a 3-4 hour toileting schedule to help reduce UTIs (urinary tract infections) and sitting in wet depends and clothes. Tenant #1 was continent of bowel. On 11/20/19 at 1:40 PM Staff A stated she worked first shift meaning she came into work at 6:00 AM. Staff A had noticed in the fall, Tenant #1 had soaked incontinence briefs in the mornings and was unsure at first if the tenant was having increased incontinence or if the overnight shift was not providing toileting assistance according to her service plan. She brought her concerns to the Health Services Director who suggested she start marking the incontinence briefs with a pen so they could tell if Tenant #1 was wearing the same brief as the day prior. Staff A stated she worked five days a week and	A 061		

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A 061	Continued From page 3	A 061		

estimated three of the five days, she found Tenant #1 in the same marked brief the next morning. When this occurred she reported it to the Health Services Director. Staff A believed other caregivers made the same reports. Staff A recalled going into Tenant #1's apartment one morning to find her with her clothing on. Staff A could tell Tenant #1 had tried to get her shirt off as she had pulled her head out of the shirt but her arms were still inside of the shirt. Staff A described Tenant #1 as someone who would not refuse her cares if a caregiver would have provided nighttime assistance to her.

On 11/21/19 at 9:50 AM Staff B stated she was told by the Health Services Director to start marking the incontinence briefs in September in response to her concerns about Tenant #1 being wet in the morning. She said she reported her concerns to the Health Services Director each time she found Tenant #1 wet, approximately six times. Staff B worked the 6:00 AM to 2:00 PM shift.

When interviewed on 11/20/19 at 10:45 AM Staff C reported she worked the 6:00 AM to 2:00 PM shift. She recalled marking the incontinence briefs for Tenant #1. Staff C said Tenant #1 went to bed right after supper and did not get up in the morning until 9:30 AM or 10:30 AM. She described some mornings finding Tenant #1 in the same incontinence brief with her sheets and nightgown soaked.

Staff D was interviewed on 11/20/19 at 2:18 PM. Staff D worked the overnight shift of 10:00 PM - 6:00 AM. She reported she had never changed Tenant #1's incontinence brief. No one had ever told her to check Tenant #1 overnight.

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A 061	Continued From page 4 On 11/21/19 at 9:20 AM Staff E stated she began working at the facility at the end of 8/2019. She worked the overnight shift. She had never met Tenant #1 and had never checked on her overnight. Staff E said when changes to tenants' service plans were written on a board in the break room. She didn't recall seeing anything about Tenant #1. The Health Services Director was interviewed on 11/20/19 at 11:55 AM. She stated she did tell the first shift employees to mark the incontinence briefs so she could tell if there was an issue with briefs not being changed. She could only recall being told two times about Tenant #1 being wet in the morning and not being told at all about her wearing marked briefs in the morning. She did not address the concerns with Tenant #1's incontinence briefs not being changed with 3rd shift staff. She stated she had informed Staff D to take Tenant #1 to the restroom overnight at the time it was added to the service plan. The information about the service plan change was also written on a board in the staff room. These findings were confirmed during an interview with the Executive Director on 11/21/19 at 1:15 PM.	A 061		
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	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure identified needs were noted in service plans for 2 of 4 tenants reviewed (Tenants #3 and #4). Findings follow: 1. Record review on 11/21/19 revealed a Resident Service Plan dated 11/7/19 for Tenant #3. The service plan identified Tenant #3 ambulated and transferred with the assistance of one with a gait belt and use of a 4 wheeled walker. The tenant's family wanted the tenant to walk to all meals in the dining room. The plan made no mention of a wheelchair. A nurse review dated 11/7/19 noted Tenant #3 required the use of a wheelchair when she was unsteady. The Health Services Director was interviewed on 11/25/19 at 9:05 AM and stated Tenant #3 used a wheelchair at times. Occasionally Tenant #3 stated her legs didn't work and on those days she required the use of a wheelchair. 2. Record review on 11/21/19 revealed a Charting Note dated 10/24/19 documenting the Health Services Director attempt to call the spouse of Tenant #4 regarding an incident with a hanger. As a result all hangers were removed from the tenant's room. On 11/20/19 at 11:55 AM the Health Services Director reported Tenant #4 had been suffering from constipation on 10/23/19 and had attempted to alleviate this by inserting a hanger into his anus to dig out the feces. Following this incident, all hangers were removed from his room as a safety	A 089		

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A 089	Continued From page 6 precaution. The tenant's most recent Resident Service Plan dated 11/15/19 did not reflect the removal of hangers from the room. 3. The Executive Director and Health Services Director confirmed these findings on 11/25/19 at 10:00 AM.	A 089		