PRINTED: 11/12/2020
FORM APPROVED

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
	S0268	A. BUILDING: _____ B. WING _____	09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF MUSCATINE	3616 DIANA QUEEN DRIVE MUSCATINE, IA 52761

(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: 43 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 8 Total census: 56 No regulatory insufficiencies were cited during the Infection Control Survey completed on 9/10/20. No regulatory insufficiencies were cited during the investigation into Complaints #90661-C, #90705-C and #92335-C. The following regulatory insufficiency was written during the investigation into Complaint #91784-C:	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	✓ 12/11/20	

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

✓ 12/12/20

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow their Fall Risk policy for 4 of 7 tenants reviewed (Tenants #1, #4, #5, #7). Findings follow: Record review on 9/9/20 revealed the program had a Fall Risk policy which noted families should be notified when a tenant fell. Tenant #1 had an Incident Report and Investigation Worksheet dated 6/9/20. There was no contact from the program to his family documented. Tenant #4 had Incident Report and Investigation Worksheets dated 6/18/20, 7/18/20 (2), 7/21/20 and 8/1/20 because of falls. There was no documentation her family was contacted regarding any of these falls. Tenant #5 had Incident Report and Investigation Worksheets dated 4/25/20 and 5/3/20 related to falls. There was no documentation her family was contacted regarding any of these falls. Tenant #7 had Incident Report and Investigation Worksheets dated 4/4/20 (2), 4/11/20, 4/18/20, 5/4/20 and 6/5/20. A notation was made on the 4/18/20 worksheet Tenant #7 notified her daughter of her falls. There was no documentation the Program notified the family of these falls.	A 003	Plan of Correction- 1. Our nursing staff asked every resident their choice of when an incident occurs do they want us to contact family and we have stated on their individual service plan under cognition tab their choice to notify or not. GDS of 4 or greater we will notify family on all incidents. 2. ED/HSD/and RCC rotates as Manager on Duty so they get the first call of all incidents that occur. It will be whoever is on call as manager on duty to call or not to call per our resident's specific service plan for each incident. 3. RCC enters all incident reports in BINDER/ database and will ensure that all incident reports have clearly stated under family who they called, date they called, and number used to call, or state resident declined if that's so stated in service plan. We will go over Monthly. 4. The date in which we had this completed or started was September 30, 2020	9-30-2020

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A 003	Continued From page 2 On on 9/10/20 at 11:10 AM the Executive Director confirmed the Fall Risk policy was not followed.	A 003		