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 10/29/2020

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 onsite. General Population Number of tenants without cognitive disorder: 37 Number of tenants with cognitive disorder: 4 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 8 Total Census: 49 No regulatory insufficiencies were cited during the investigation of Complaint #93742-C or the onsite infection control survey.. The following regulatory insufficiencies were cited during the investigation into Complaints 93137-C, 93138-C and 91278-C.	A 000		
A 146	481-67.3(9) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(9) To be free from restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure restraints were not	A 146	1/12/21 Per conversation with the Executive Director, she will oversee overall compliance of the POC	

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

DD 1/12/21

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A 146	Continued From page 1 utilized for 1 of 5 tenants reviewed (Tenant #4). Findings follow: Review of Charting Notes for Tenant #4 on 10/20/20 revealed she received a COVID-19 test on 5/26/20 after she returned from an inpatient stay at the hospital. Staff A reported on 10/21/20 at 3:20 PM she worked in the dietary department and was taking a cart of food to the memory care unit. Tenant #4 was in her apartment with the Health Services Director. The Health Services Director stated she needed to give Tenant #4 a COVID-19 test, but Tenant #4 was not receptive as she wanted to do the test herself. Staff A recalled seeing Tenant #4 swinging her arms at the Health Services Director. The Health Services Director asked Staff A to hold Tenant #4's hands while she completed the process of swabbing Tenant #4's nose. Another (former) staff present was asked to hold Tenant #4's legs. The Health Services Director stated on 10/27/20 at 2:30 PM she needed to do a COVID-19 test on Tenant #4 per policy. She asked a (former) staff person to help her with this process and they entered Tenant #4's apartment. Tenant #4 was sitting on her couch and the Health Services Director modeled the testing process for her but when she went to conduct the test, Tenant #4 was not agreeable with having the test done. She did lay down on her couch but then began swinging her arms at the Health Services Director. The Health Services Director asked the former staff to hold Tenant #4's arms and called in Staff A to help hold Tenant #4's legs. The Executive Director and Health Services	A 146	All residents will be free from restraints at all times & can refuse tests and treatments at any time. This will start immediately.	

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A 146	Continued From page 2 Director confirmed these findings on 10/27/20 at 2:50 PM.	A 146		
A 076	481-69.25(1)n Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure required paperwork was in the file for 1 of 4 tenants reviewed with a power of attorney (Tenant #3). Findings follow: Record review on 10/20/20 revealed the program did not have power of attorney paperwork for Tenant #3. The Executive Director confirmed on 10/27/20 at 8:27 AM she could not find the Power of Attorney paperwork in Tenant #3's record. She reported she had seen the paperwork indicating Tenant #3's daughter was the Power of Attorney upon the tenant's admission. The Executive Director had asked the daughter many times to bring a copy of the paperwork back to the program but she had not done so.	A 076	All charts will have documentation that is to be maintained by the program. The Executive Director has went through all charts to ensure all paperwork is in them, and has made a new checklist to ensure all documentation is collected upon move in. The Director will be responsible for ensuring this is done. This has been corrected immediately.	
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care	A 085		

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A 085	Continued From page 3 or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure service plans were updated when a significant change occurred for 4 of 5 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1) On 10/20/20 a review of Charting Notes for Tenant #1 revealed on 8/18/20 she had +3 pitting edema with weeping to her bilateral lower extremities. Tenant #1 was refused to wear her TED hose stating they were uncomfortable. The Health Services Director (HSD) sent a fax to Tenant #1's Primary Care Provider (PCP) requesting an order for a diuretic medication (Lasix) to use as needed. The PCP approved the order for Lasix on 8/19/20 and also asked the HSD to wrap Tenant #3's legs daily with loose ace bandages and to encourage Tenant #1 to elevate her legs. The HSD applied telfa to the blisters bilaterally and wrapped Tenant #1's legs with a soft roll gauze and applied tubi-grip. She ordered ace bandages for Tenant #1. On 8/21/20 the HSD charted Tenant #1 was removing the leg wraps and would not keep her feet elevated. Both of her feet had +3 pitting edema with blisters and open blisters. The nurse expressed her concern to the tenant's daughter and also left a message for the PCP who asked for Tenant #1 to be sent to the Emergency Room. Tenant #1	A 085	The Health Services Director (HSD) Will ensure all care plans are up to date per residents needs & that all care plans have interventions in place when needed. The Executive Director will continue reviewing all care plans to ensure this is done. This has been corrected immediately.	

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A 085	Continued From page 4 was sent back from the Emergency Room after having the blisters decompressed on the tops of both of her feet. Tenant #1 had falls in her apartment on 8/23/20 and 8/24/20. The HSD changed the bandages to Tenant #1's feet on 8/25/20 and applied silvasorb gel and telfa. She wrapped both her feet in soft gauze, applied ace wraps with tubi-grip over. Tenant #1's edema had decreased but was still present and required wrap and elevation. Tenant #1 was found on the floor next to her bed with a pillow and blanket on 9/17/20. She was found on the floor of her bathroom with a long thin bruise to the left side of her back on 9/20/20. Tenant #1's Resident Service Plan was dated 8/17/20. According to the plan she wore TED Hose and needed assistance with putting them on in the morning and taking them off in the evening. The plan did not address any other type of bandage or the need for staff to encourage Tenant #1 to elevate her legs. It noted she was at average risk for falls. It had not been updated to address her change in condition. 2) On 10/20/20 a review of Charting Notes revealed Tenant #2 was very confused on 9/15/20 and attempted elopement 4 times that evening. Tenant #2 was hallucinating about her parents and could not remember where she lived. On 9/28/20, a late note was entered for 9/26/20 identifying Tenant #2 had eloped from the building at approximately 4:20 PM. Tenant #2 was found across the road from the front of the facility talking with a passerby and requesting this person call 911 as she was being held hostage. Tenant #2 was returned to the facility without incident. She was very agitated on 9/29/20 and continuously talking about her parents who were	A 085		

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A 085	Continued From page 5 deceased. Tenant #2 was exit-seeking and required 1:1 supervision. The HSD contacted Tenant #2's PCP for additional medication to help calm her down and an appointment was scheduled for 10/1/20. Tenant #2 attempted to leave the program on 10/5/20 stating she needed to get her parents from the hospital. On 10/7/20, Tenant #2 attempted to leave the building by exiting the program through the 200 hall stating she needed to check on her mother. It was noted she started an increase on medication that morning. A 30-day assessment was completed for Tenant #2 on 10/9/20. Tenant #2's Resident Service Plan dated 9/4/20 indicated her thought disorder symptoms would be managed by staff but listed no interventions on how they were to do this. Her plan noted a significant history of mental illness, hoarding and Alzheimer's Disease. It also identified she was at a high risk to elope and she was not pleased about living at the Program. Tenant #2's service plan was not updated following her elopement attempts or when there was a need to increase her supervision levels. 3) On 10/20/20 a review of Tenant #3's Charting Notes revealed she exited the building and walked down the sidewalk on 8/8/20. On 8/14/20, Tenant #3 saw her primary care provider and received a written order to wear compression stockings. She was also to follow up with Home Health Care for physical therapy. Tenant #3 left the building and was found by construction workers in the road on 8/18/20. Tenant #3 did not have her walker and was very confused and refused to enter the building. Two staff members were needed to help her back to the building. Tenant #3's daughter was contacted about	A 085		

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A 085	Continued From page 6 moving her mother to the Memory Care Unit of the Program and agreed it would be a good setting for her. Tenant #3 moved into an apartment in the Memory Care Unit on 8/19/20. She was found on the floor during rounds on 8/23/20 and said she was crawling to the bathroom. Tenant #3 was pinned between her bed and walker on 8/24/20 and received a small skin tear. Tenant #3 was found on the floor of her room at 8/25/20. She had a small red mark on her back from leaning against her bed. On 8/27/20, she was found on the floor wrapped in her blankets and reported falling out of bed without an injury. A late entry dated 8/31/20 noted the HSD received a call from the Resident Care Coordinator informing her Tenant #3 had spilled coffee on her lap. Tenant #3 got up from a chair unassisted and fell to the floor on 9/8/20. It was noted she had been advised numerous times to use her pendant for assistance to ambulate or change her position. Tenant #3 was assessed on 8/31/20 and found to be lethargic with a right sided head tilt and unable to smile or make a facial grimace. She was completely unable to stand and could not perform grips of her bilateral hands. A decision was made by the HSD to send her to the emergency room. A nurse at the hospital informed the HSD Tenant #3 was being sent to the hospice house for a brain bleed. Tenant #3 had a Resident Service Plan dated 8/7/20. The service plan was written after Tenant #3 returned to the Program following a hospitalization for a stable left subdural hematoma which occurred on 8/1/20. A review of Tenant #3's Resident Service Plan revealed she had demonstrated an ability to use the pendent call system although charting notes. Tenant #3's service plan did not mention she was to wear	A 085		

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A 085	Continued From page 7 compression stockings. Her plan was not updated when Physical Therapy was added to plan, when she moved to the Memory Care Program or when she showed exit seeking tendencies. 4) On 10/20/20 a review of Tenant #4's Charting Notes revealed she was found sitting on the floor near her bed on 6/6/20 without note of any injury. Tenant #4 was found on her bottom sitting upright in her restroom when staff did checks. On 6/21/20 at 11:50 PM, Tenant #4 walked around a table and fell, hitting her head on the right side. Tenant #4 also complained of pain in her right hip. She was sent to the hospital via ambulance and returned on 6/22/20 at 3:00 AM with a diagnosis of a concussion. Tenant #4 was heard calling out for help on 6/29/20. Staff found her in her apartment on the floor in front of her closet. Staff removed items of clutter from the walkway. Tenant #4 was found lying on the floor by her bed on 7/1/20 when a caregiver went to pass morning meds. She did not have an injury. Tenant #4 fell in the dining room when attempting to walk from table to table without using her walker. She obtained a goose egg on the left side of her head. Tenant #4 was sent to the emergency room and received a CT scan and neck X-ray which were all within normal limits. Tenant #4 fell on the floor when trying to pick an item up from the floor on 7/26/20 without an injury. She was found on the floor on 7/28/20 at 5:00 AM during rounds and had a complaint of knee pain. Tenant #4 was found on the floor of her room between her bed and television with an abrasion that was bleeding to her left elbow on 8/6/20. She fell from her bed and hit her head on the right temple causing a large bruise. Tenant #4 was sent to the hospital. On 9/24/20, Tenant #24 leaned over	A 085		

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A 085	Continued From page 8 her walker to put a glass in the sink and stumbled and fell. She denied any pain but had an abrasion to her left knee. On 10/7/20, Tenant #4 fell out of bed and had a large hematoma to the left side of her face and eye. She was sent to the hospital but returned by ambulance with the diagnosis of hematoma. Tenant #4's Resident Service Plan was updated as part of a quarterly review according to a Nurse Review written on 7/28/20. Falls and methods to decrease falls were not addressed in the service plan. 5) The Executive Director and HSD confirmed these findings on 10/27/20 at 2:50 PM.	A 085		
A 094	481-69.27(1)a 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: 69.27(1)a To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.	A 094	The Health Services Director (HSD) will ensure that when charting in QuickMar she will note if it is a Nurse's Note or if it is a Nurse Review. Nurse Reviews will be done when a Significant change is noticed. This will be corrected immediately.	

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A 094	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure nurse reviews were completed with a significant change for 4 of 5 tenants reviewed (Tenants #1, #2, #3, #4). Findings follow: 1) Tenant #1's Resident Service Plan dated 8/17/20 noted she wore TED hose and needed assistance with putting them on in the morning and taking them off in the evening. Her plan also noted her skin was pink, warm, dry and intact. She was noted to have no falls within the 30 previous days and was at an average risk for falls. On 10/20/20 a review of Charting Notes for Tenant #1 revealed on 8/18/20 she had +3 pitting edema with weeping to her bilateral lower extremities. Tenant #1 was refused to wear her TED hose stating they were uncomfortable. The Health Services Director (HSD) sent a fax to Tenant #1's Primary Care Provider (PCP) requesting an order for a diuretic medication (Lasix) to use as needed. The PCP approved the order for Lasix on 8/19/20 and also asked the HSD to wrap Tenant #3's legs daily with loose ace bandages and to encourage Tenant #1 to elevate her legs. The HSD applied telfa to the blisters bilaterally and wrapped Tenant #1's legs with a soft roll gauze and applied tubi-grip. She ordered ace bandages for Tenant #1. On 8/21/20 the HSD charted Tenant #1 was removing the leg wraps and would not keep her feet elevated. Both of her feet had +3 pitting edema with blisters and open blisters. The nurse expressed her concern to the tenant's daughter and also left	A 094		

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A 094	Continued From page 10 a message for the PCP who asked for Tenant #1 to be sent to the Emergency Room. Tenant #1 was sent back from the Emergency Room after having the blisters decompressed on the tops of both of her feet. Tenant #1 had falls in her apartment on 8/23/20 and 8/24/20. The HSD changed the bandages to Tenant #1's feet on 8/25/20 and applied silvasorb gel and telfa. She wrapped both her feet in soft gauze, applied ace wraps with tubi-grip over. Tenant #1's edema had decreased but was still present and required wrap and elevation. Tenant #1 was found on the floor next to her bed with a pillow and blanket on 9/17/20. She was found on the floor of her bathroom with a long thin bruise to the left side of her back on 9/20/20. Nurse reviews addressing Tenant #1's significant change in condition related to her edema or falls could not be located. 2) Tenant #2's initial Resident Service Plan dated 9/4/20 indicated her thought disorder symptoms would be managed by staff. Her plan noted a significant history of mental illness, hoarding and Alzheimer's disease. It also identified she was at a high risk to elope and she was not pleased about living at the Program. A review of Charting Notes revealed Tenant #2 was very confused on 9/15/20 and attempted elopement 4 times that evening. Tenant #2 was hallucinating about her parents and could not remember where she lived. On 9/28/20, a late note was entered for 9/26/20 identifying Tenant #2 had eloped from the building at approximately 4:20 PM. Tenant #2 was found across the road from the front of the facility talking with a	A 094		

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A 094	Continued From page 11 passerby and requesting this person call 911 as she was being held hostage. Tenant #2 was returned to the facility without incident. She was very agitated on 9/29/20 and continuously talking about her parents who were deceased. Tenant #2 was exit-seeking and required 1:1 supervision. The HSD contacted Tenant #2's PCP for additional medication to help calm her down and an appointment was scheduled for 10/1/20. Tenant #2 attempted to leave the program on 10/5/20 stating she needed to get her parents from the hospital. On 10/7/20, Tenant #2 attempted to leave the building by exiting the program through the 200 hall stating she needed to check on her mother. It was noted she started an increase on medication that morning. Nurse reviews addressing Tenant #2's significant change in condition related to exit-seeking behaviors and hallucinations could not be located. 3) Tenant #3 had a Resident Service Plan dated 8/7/20. The service plan was written after Tenant #3 returned to the program following a hospitalization for a stable left subdural hematoma which occurred on 8/1/20. Tenant #3's service plan indicated she had no history of elopement. It noted she was at a high risk for falls. The plan documented the tenant had no cognitive impairment and she had demonstrated the ability to use the pendent call system. Review of Tenant #3's Charting Notes revealed she exited the building and walked down the sidewalk on 8/8/20. On 8/14/20, Tenant #3 saw her primary care provider and received a written order to wear compression stockings. She was also to follow up with Home Health Care for	A 094		

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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
A 094	Continued From page 12 physical therapy. Tenant #3 left the building and was found by construction workers in the road on 8/18/20. Tenant #3 did not have her walker and was very confused and refused to enter the building. Two staff members were needed to help her back to the building. Tenant #3's daughter was contacted about moving her mother to the Memory Care Unit of the Program and agreed it would be a good setting for her. Tenant #3 moved into an apartment in the Memory Care Unit on 8/19/20. She was found on the floor during rounds on 8/23/20 and said she was crawling to the bathroom. Tenant #3 was pinned between her bed and walker on 8/24/20 and received a small skin tear. Tenant #3 was found on the floor of her room at 8/25/20. She had a small red mark on her back from leaning against her bed. On 8/27/20, she was found on the floor wrapped in her blankets and reported falling out of bed without an injury. A late entry dated 8/31/20 noted the HSD received a call from the Resident Care Coordinator informing her Tenant #3 had spilled coffee on her lap. Tenant #3 got up from a chair unassisted and fell to the floor on 9/8/20. It was noted she had been advised numerous times to use her pendant for assistance to ambulate or change her position. Tenant #3 was assessed on 8/31/20 and found to be lethargic with a right sided head tilt and unable to smile or make a facial grimace. She was completely unable to stand and could not perform grips of her bilateral hands. A decision was made by the HSD to send her to the emergency room. A nurse at the hospital informed the HSD Tenant #3 was being sent to the hospice house for a brain bleed. Nurse reviews addressing Tenant #3's significant change in condition related to exit-seeking,	A 094		

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 10/29/2020

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 094	Continued From page 13 change in memory, inability to use the pendent call system, falls and beginning physical therapy could not be located. 4) Tenant #4's Resident Service Plan dated 4/25/20 indicated she had a history of falls but no recent emergency room visits. She was noted to be at a high risk for falls. A Nurse Review was written for Tenant #4 on 7/28/20 but it was noted to be a quarterly review. A review of Tenant #4's Charting Notes revealed she was found sitting on the floor near her bed on 6/6/20 without note of any injury. Tenant #4 was found on her bottom sitting upright in her restroom when staff did checks. On 6/21/20 at 11:50 PM, Tenant #4 walked around a table and fell, hitting her head on the right side. Tenant #4 also complained of pain in her right hip. She was sent to the hospital via ambulance and returned on 6/22/20 at 3:00 AM with a diagnosis of a concussion. Tenant #4 was heard calling out for help on 6/29/20. Staff found her in her apartment on the floor in front of her closet. Staff removed items of clutter from the walkway. Tenant #4 was found lying on the floor by her bed on 7/1/20 when a caregiver went to pass morning meds. She did not have an injury. Tenant #4 fell in the dining room when attempting to walk from table to table without using her walker. She obtained a goose egg on the left side of her head. Tenant #4 was sent to the emergency room and received a CT scan and neck X-ray which were all within normal limits. Tenant #4 fell on the floor when trying to pick an item up from the floor on 7/26/20 without an injury. She was found on the floor on 7/28/20 at 5:00 AM during rounds and had a complaint of knee pain. Tenant #4 was found on the floor of her room between her bed and	A 094		

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
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A 094	Continued From page 14 television with an abrasion that was bleeding to her left elbow on 8/6/20. She fell from her bed and hit her head on the right temple causing a large bruise. Tenant #4 was sent to the hospital. On 9/24/20, Tenant #24 leaned over her walker to put a glass in the sink and stumbled and fell. She denied any pain but had an abrasion to her left knee. On 10/7/20, Tenant #4 fell out of bed and had a large hematoma to the left side of her face and eye. She was sent to the hospital but returned by ambulance with the diagnosis of hematoma. Nurse reviews addressing Tenant #4's significant change in condition related to falls or emergency room visits could be located. 5) The Executive Director and HSD confirmed these findings on 10/27/20 at 2:50 PM.	A 094		