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
	S0127	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET PARK PLACE	3730 PENNSYLVANIA AVE DUBUQUE, IA 52002

(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: 45 Number of tenants with cognitive disorder: 3 Total Census of General Population: 48 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 9 Total Census of Memory Care Unit: 9 Total Population of Program: 57 No insufficiencies were cited during the investigation of Complaint #94457-C and Complaint #94718-C or the onsite infection control survey. The following insufficiency was cited during the investigation of Complaint #95128-C.	A 000		
A 160	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 interview and record review the program failed to provide adequate care and	A 160	Plan of Correction is attached ✓ 4/14/21	

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
	S0127	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET PARK PLACE	3730 PENNSYLVANIA AVE DUBUQUE, IA 52002

(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 160	Continued From page 1 treament for 1 of 5 current tenants reviewed (Tenant #1). Findings include: On 1/19/21 review of an incident report written by RN A dated 1/5/21 revealed staff noted Tenant #1 was not using her right arm to eat with at supper. The tenant was unable to lift her right arm. When staff assisted the tenant in changing clothes she observed multiple reddish, purple bruises on her right shoulder, breast and underarm areas. Tenant #1 had no complaints of pain but showed discomfort to the touch. The tenant denied falling when asked what happened. The report noted the tenant often fell and got herself back up. She was sent to the hospital for evaluation and treatment. A progress note documented by RN A dated 1/6/21 revealed the tenant was admitted to the hospital with a fractured rib and clavicle. A lump was also found in her throat. During an interview on 1/13/21 at 1:48 pm, Staff E stated she received a call at home on 1/5/21 from Registered Nurse (RN) A asking if she had seen any bruising on Tenant #1 during first shift that day. Staff E responded she had assisted Tenant #1 in getting dressed in the morning but noticed no bruising. Later in the shift the tenant complained of shoulder pain and she told RN B about the compliant. On 1/19/21 review of the communication log utilized by uncertified staff revealed on 1/5/21, Staff E documented Tenant #1 complained of shoulder pain on first shift and she would notify the nurse. On 1/20/21 at 11:20 am, RN B stated he had no recollection of being told Tenant #1 had shoulder pain during 1st shift on 1/5/21.	A 160		

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
	S0127	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET PARK PLACE	3730 PENNSYLVANIA AVE DUBUQUE, IA 52002

(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 160	Continued From page 2 Tenant #1's nurse's notes lacked documentation regarding any shoulder pain on 1/5/21. Tenant #1's medication administration record for 1/5/21 revealed no pain medications were given. On 1/20/21 at 1:03 pm, the Clinical Care Specialist and Program Manager confirmed the above finding.	A 160		

Complaint#: 95128-C

Plan of Correction (POQ Submitted For:

- Investigation Date: 1/12/21 through 1/20/21

A. Written Occupancy Agreement ***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.

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

a. When RN was made aware of the potential pain, resident sent for evaluation the night of 1/6/2021, hospitalized until 1/8/2021 and returned with a significant change and update to service plan on 1/8/2021.

2. Actions program taking to protect tenants in similar situations:

a. Education to be provided to all staff regarding fall procedure, incident reporting and communication to nurse by 3/30/2021.

3. Measures taken to ensure problem does not recur:

a. The Program Director, Nurse or designee will ensure new hires are educated on fall procedure, incident reporting and community to nurse.

The Program will be in substantial compliance by March 30, 2021.

Disclaimer for POC

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the program of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.