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 11/04/2021 |

| 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<br><br>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.<br><br>General Population<br>Number of tenants without cognitive disorder: 43<br>Number of tenants with cognitive disorder: 4<br>Total Census of General Population : 47<br><br>Memory Care Unit<br>Number of tenants without cognitive disorder: 9<br>Number of tenants with cognitive disorder: 9<br>Total Census of Memory Care Unit: 9<br><br>Total Census of Assisted Living Program for People with Dementia : 56<br><br>The following regulatory insufficiencies were cited during the investigation of Complaint #96754-C.<br><br>In addition to this investigation, an onsite infection control survey was conducted. No deficiencies were cited during this survey. | A 000 | Plan of Correction is Attached | |
| A 160 | 481-67.3(2) Tenant Rights<br><br>481-67.3 Tenant rights. All tenants have the following rights:<br><br>67.3(2) To receive care, treatment and services which are adequate and appropriate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the | A 160 | | |

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| A 160 | Continued From page 1<br>Program failed to provide adequate and appropriate cares for 1 of 3 tenants reviewed (Tenant #2). Findings include:<br><br>A review of Tenant #2's record on 4/13/21 revealed an admission date of 10/16/12. Tenant # 2's most recent cognitive evaluation dated 4/5/21 showed a score of 6 on the Global Deterioration Scale (GDS) indicating severe cognitive decline.<br><br>A service plan dated 4/16/21 revealed Tenant #2 required encouragement to take showers as she disliked bathing. Staff had to set the water temperature, assist to wash, rinse and dry off. Staff was to come back several times to attempt shower prompts if Tenant #2 refused. Staff were to provide shower assistance with Tenant #3 three times a week.<br><br>On 4/12/21 at 1:02 PM, Staff B stated Tenant #2 had got to the point where she frequently refused her bath/showers. The staff used waterless shampoo on her hair due to these refusals.<br><br>During a review of task sheets for Tenant #2 on 4/13/21, the task sheet for March of 2021 had no documentation indicaitng if the resident was assisted in bathing or refused assistance for bathing. It was unknown if Tenant #2 was bathed three times a week during the month of March.<br><br>On 11/4/21 at 2:00 PM, the Manager confirmed the above findings. | A 160 | | |
| A 330 | 481-69.25(1)q Tenant Documents<br><br>69.25(1) Documentation for each tenant shall be maintained by the program and shall include: | A 330 | | |

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 330 | Continued From page 2<br><br>q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to implement task sheets for the completion of routine personal care assistance for 1 of 3 tenants reviewed (Tenant #2) Findings include:<br><br>A review of Tenant #2's record on 4/13/21 revealed an admission date of 10/16/12. Tenant # 2's most recent cognitive evaluation dated 4/5/21 showed a score of 6 on the Global Deterioration Scale (GDS) indicating severe cognitive decline.<br><br>A service plan dated 4/16/21, revealed Tenant #2 wore glasses. Staff was to occasionally assist Tenant #2 with cleaning her glasses. The service plan indicated staff needed to assist Tenant #2 on occasion with brushing her teeth and combing her hair as needed.<br><br>A review of task sheets for Tenant #2 on 4/13/21, revealed a lack of task documentation for glasses cleaning, toothbrushing or hair combing.<br><br>On 11/4/21 at 2:00 PM, the Manager confirmed the above finding. | A 330 | | |

**Sunset Park Place**
3730 Pennsylvania Avenue, Dubuque, IA 52002

Iowa Department of Inspection & Appeals
Deb Dixon
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiency cited during the 4/7/2021 to 11/4/2021 Infection Control Survey and Complaint visit completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69, pertaining to regulatory insufficiencies.

**Date:** 12/6/2021
**Complaint Intake #:** Investigation of Complaint #96754-C

**Plan of Correction (POC) Submitted For:**

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**POC:** 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 and appropriate cares for 1 of 3 tenants reviewed.

**Program POC:**

1. Elements detailing how this was corrected for residents:
   a. Community has completed training for Director, Assistant Director and Health Care Coordinator regarding documentation compliance for Resident specific Task Documentation.
2. Actions program taking to protect tenants in similar situations:
   a. JSL team re-educated Director, Assistant Director and Health Care Coordinator regarding documentation compliance for Resident specific Task Documentation.
3. Measures taken to ensure problem does not recur:
   a. Community has completed training for Director, Assistant Director and Health Care Coordinator regarding

documentation compliance for Resident specific Task Documentation.

b. Increased auditing of electronic health record dashboard throughout the day during the week and missing documentation report follow up for the weekends will assure this does not happen going forward

c. The Community will audit missing documentation reports weekly for 4 weeks, 2 times per month for one month and then as determined by the Director, Assistant Director, Health Care Coordinator, or designee.

4. Program plans to monitor performance to ensure compliance:
   a. Monitoring of resident refusals of showers will be reviewed as needed daily, weekly, monthly, as determined by the Community Director or designee.
   b. Follow-up will be completed on refusals by the Health Care Coordinator or Designee.

**POC:** 481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to implement task sheets for the completion of routine personal care assistance for 1 of 3 tenants reviewed.

**Program POC:**

1. Elements detailing how this was corrected for residents:
   a. Community has completed training for Director, Assistant Director and Health Care Coordinator regarding documentation compliance for Resident specific Task Documentation.
2. Actions program taking to protect tenants in similar situations:
   a. JSL team re-educated Director, Assistant Director and Health Care Coordinator regarding documentation compliance for Resident specific Task Documentation.
3. Measures taken to ensure problem does not recur:
   a. Community has completed training for Director, Assistant Director and Health Care Coordinator regarding documentation compliance for Resident specific Task Documentation.
   b. Increased auditing of electronic health record dashboard throughout the day during the week and missing documentation report follow up for the weekends will assure this does not happen going forward
   c. The Community will audit missing documentation reports weekly for 4 weeks, 2 times per month for one month and then as determined by the Director, Assistant Director, Health Care Coordinator, or designee.

4. Program plans to monitor performance to ensure compliance:
   a. Monitoring of resident refusals of showers will be reviewed as needed daily, weekly, monthly, as determined by the Community Director or designee.
   b. Follow-up will be completed on refusals by the Health Care Coordinator or Designee.

*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider 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.*

Thank you for your time and consideration in correcting these important matters.

Sincerely,

Jerry Bell, Community Director