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 09/05/2023

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

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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. Number of tenants without cognitive impairment: 46 Number of tenants with cognitive impairment: 7 Total census: 53 The following regulatory insuffiencies were cited during the investigation of Mandatory Report #114766-M, Incident #115178-I, Complaint #115134-C, Complaint #115047-C, Complaint #115039-C, and Complaint #113213-C.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the written policy regarding the identification and reporting of dependent adult abuse for 1 of 5 tenants reviewed (Tenant #5). Findings include: 1. On 8/28/23 a review of incident reports revealed a report dated 8/2/23 for Tenant #5 indicating a staff member reported to the Administrator that on 7/26/23 she observed a coworker get Tenant #5 up at 4:30 am for a shower which caused the tenant to become upset, confused and tearful. The staff member stated the staff person giving the shower did not	A 150		

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A 150	Continued From page 1	A 150		

let Tenant #5 sit down because she felt it would be too difficult to get her back up. The staff further reported the staff person giving the shower also shampooed Tenant #5's hair without covering her face.

2. On 8/28/23 a review of Tenant #5's record revealed she required physical assistance in and out of the shower and with washing.

3. On 8/29/23 at 11:30 am, the Administrator stated that on 8/2/23, Staff A and Staff C slid notes under her door to inform her of an incident they had concerns with that occurred on 7/26/23 regarding Tenant #5 and Staff I. The Administrator immediately called Staff I into her office to discuss the allegations. Staff I was placed on suspension until an investigation was complete. The Administrator reported the allegations to the Department on 8/3/23. The Administrator confirmed Staff I had worked 2 shifts between the date of the incident on 7/26/23 and the date Staff A and Staff C reported their concerns on 8/2/23. The Administrator confirmed Staff A was trained on the Program's abuse reporting policy on 6/20/23 and Staff C was trained on 7/17/23. The Administrator stated both staff indicated they reported the concerns late as they were upset and needed to process the information.

4. On 8/28/23 at 10:50 am, Staff A stated she was working 3rd shift from 7/25/23 into 7/26/23. Staff I arrived to work between 2:00 and 2:30 am. Staff A observed Staff I take Tenant #5 into the shower at around 4:30 am. Prior to the shower she observed Staff I get Tenant #5 up out of bed very suddenly in a somewhat rough manner. Staff I appeared to demand for Tenant #5 to get up. Once the shower was turned on, Tenant #5

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A 150	Continued From page 2	A 150		

began to cry. Staff A heard Staff C (who was a new hire trainee) ask if she should go get a shower chair. Staff A heard Staff I say yes. Once Staff C returned to the shower area with the shower chair, Staff I stated she was not going to let Tenant #5 sit down because "it would be too big of a bitch to get her up out of the chair." Staff A stated Staff I made Tenant #5 stand the entire time even though she appeared to want to sit down. Staff A also heard Tenant #5 say, "water in my eyes."

5. On 8/28/23 at 3:20 pm, Staff C stated she observed Staff I take Tenant #5 into the shower around 6:00 am. Staff C stated she could tell Tenant #5 was nervous and hesitant when she went into the shower. She observed Tenant #5 crying and Staff I telling her she didn't need to cry. Staff I told Tenant #5 to look up so that she could wash her hair. Tenant #5 didn't put her head up and Staff I washed her hair anyway causing water/soap to run down into the tenant's eyes. Staff C told Staff I to stop and grabbed the washcloth sitting to the side and rolled it up and placed it on Tenant #5's forehead. Staff C added that she went to get a shower chair for Tenant #5 to sit down on but Staff I stated she wasn't going to let her sit down or it would be a "bitch" to get her back up.

6. On 8/30/23 the "Abuse, Neglect, Misappropriation, and Injuries of Unknown Sources" policy was reviewed. The policy directive for any team member in the Program was to immediately report their concerns to the Director or Administrator if they felt that they had witnessed potential abuse. Although Staff A and Staff C had been trained on this policy and the 2 hour dependent adult abuse training, they failed to report their concerns to the Administrator until

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A 150	Continued From page 3 a week after the incident, therefore not following the policy. 7. On 9/5/23 at 10:15 am, the Administrator confirmed the above finding.	A 150		
D103	481--52.2(2)a Reporting Suspected Dependent Adult Abuse 52.2(2) Reporting suspected dependent adult abuse in facilities or programs. a. If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within 24 hours of such notification or the next business day. This REQUIREMENT is not met as evidenced by: Based on interview and record review, Program staff failed to notify the Administrator immediately of suspected abuse regarding 1 of 5 tenants reviewed (Tenant #5). Findings follow: On 8/29/23 at 11:30 am, the Administrator stated that on 8/2/23, Staff A and Staff C slid notes under her door to inform her of an incident they had concerns with that occurred on 7/26/23 regarding Tenant #5 and Staff I. The Administrator immediately called Staff I into her	D103		

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D103	Continued From page 4 office to discuss the allegations. Staff I was placed on suspension until an investigation was complete. The Administrator reported the allegations to the Department on 8/3/23. The Administrator confirmed Staff I had worked 2 shifts between the date of the incident on 7/26/23 and the date Staff A and Staff C reported their concerns on 8/2/23. She confirmed Staff A was trained on the Program's abuse reporting policy on 6/20/23 and Staff C was trained on 7/17/23. The Administrator stated both staff indicated they reported the concerns late as they were upset and needed to process the information.	D103		