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
	S0208	A. BUILDING: _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

(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: 35 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 5 Total Census: 40 There were no regulatory insufficiencies cited during the onsite infection control survey.. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia and the investigation of Incident 96255-I.	A 000	✓ 6/16/21	
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).	A 345	Per an email by the Executive Director he will ensure overall compliance of the POC. DT	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DT 6/16/21

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A 345	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure 4 of 6 caregivers hired since July 2020 received training from the registered nurse within 30 days of hire (Staff A, Staff B, Staff E and Staff F). Findings follow: Record review of personnel files on 3/30/21 revealed Staff A had a hire date of 10/13/20. The registered nurse at the time did not ensure Staff A was fully trained until 11/25/20. Staff B was hired on 12/4/20. The Health Services Director documented Staff B was fully trained on 2/25/21. Staff E was hired on 9/17/20. The registered nurse at the time did not ensure Staff E was fully trained until 10/21/20. Staff F was hired on 1/4/21. The Health Services Director documented Staff F was fully trained on 2/14/21. The Executive Director and Health Services Director confirmed these findings on 3/31/21 at 1:15 PM.	A 345	The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenant. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. Within 30 days of beginning employment, all program staff shall receive training by the programs registered nurse. Employee chart audits will be completed with the QAPI process and as needed by the community. Completed by 6/7/2021.	
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is	A 160		

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A 160	Continued From page 2 sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to discharge 1 of 2 tenants reviewed who displayed physical and verbal aggression (Tenant #1). Findings follow: Record review on 3/29/21 revealed the following for Tenant #1: - on 1/5/21 he was very aggressive towards a female tenant for getting a paper towel. He yelled and raised his fist at her in front of other tenants. Later he became aggressive toward another tenant, walked up to him and told him to get out of his way before he punched the tenant. - on 1/7/21 Tenant #1 got angry when staff asked him to take his pills and grabbed staff by the collar of her shirt and shook her. - on the afternoon of 1/9/21, Tenant #1 tried to urinate on a dining room chair. When staff tried to redirect him, he yelled and raised his hand and said he would smack the staff person. - on 1/15/21 staff tried to provide Tenant #1 with step-by-step instructions when doing his morning cares. He became very violent and started to hit and scream at the caregiver. - on 1/26/21 Tenant #1 raised his fist to Tenant #2 as if he was going to hit him in the face. - on 2/3/21 he called tenants and staff names. - on 2/4/21 the tenant was noted to be very angry. He yelled, screamed and raised his hands to other tenants. He told Tenant #2 he was going to punch his lights out. - on 2/7/21 staff was putting a laundry basket by a tenant's door when Tenant #1 came up to her, yelled and then pushed her twice. The same staff	A 160	When a resident is dangerous to self or other tenants or staff including but not limited to a tenant who: Despite intervention chronically elopes is sexually or physically aggressive or abusive, or display unmanageable verbal abuse or aggression, Sunnybrook at Mt. Pleasant will issue a 30 day notice and assist with finding placement for the individual resident. Completed by 6/7/2021	

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A 160	Continued From page 3	A 160		

tried to change Tenant #1's urine soaked socks and got punched in the face.
- on 2/13/21 he was verbally aggressive towards the other residents. He had two altercations with Tenant #2 which led to the other tenant raising his fist to Tenant #1.
- on 2/14/21 Tenant #1 became verbally and physically aggressive when staff assisted him in the restroom. He grabbed the caregivers' arms and shook them. He yelled and screamed the whole time they were assisting him.
- on 2/18/21 Tenant #1 told another tenant "hi" and when she didn't hear him, he called her a name and tried to grab her arms.
- on 2/23/21 Tenant #1 told staff he needed to have a bowel movement and kept walking towards the dining room chairs trying to sit down. The staff person tried to lead him toward the bathroom and he became upset. He yelled an grabbed the staff's arm, digging his naiks ito it. He then hit her in the neck. Later in the afternoon, Tenant #1 grabbed Tenant #6's hand and squeezed it until she showed signs of pain.
- on 2/24/21 Tenant #1 grabbed a staff person's hand and arm, squeezing and twisting it until she started to cry.
- Staff saw Tenant #1 preparing to urinate on the floor in the dining area on 2/27/21. They assisted him to the bathroom, even though he yelled and raised his fist.
- Tenant #1 soiled himself on 2/28/21 and was taking the feces from his undergarment and throwing it on the floor. When a staff person came in to help him change his clothes, he started punching and kicking her. It took almost an hour to get him cleaned and changed as he continued to hit throughout the process.
- on 3/3/21 Tenant #1 hit, spit and name-called caregivers who tried to assist with changing his soiled clothing.

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A 160	Continued From page 4 - Tenant #1 walked past Tenant #4, grabbed her shoulders and shook her on 3/7/21. - on 3/9/21 Tenant #1 raised his fists to Tenant #2 and grabbed the staff who stepped in to break up the altercation. He told a staff member who was assisting him in the bathroom he would tear her guts out. - the tenant grabbed two staff members by their arms on 3/10/21. - on 3/11/21 he yelled at staff and tenants.Tenant #1 hit and spit on staff when they helped him go to the restroom. - on 3/12/21 Tenant #1 yelled at three tenants. He acted as if he was going to put his hands around Tenant #4's neck but staff intervened - on 3/13/21 the tenant grabbed another tenant's arns and tried to bite her finger on 3/13/21. - staff noticed Tenant #1's pants were wet on 3/15/21 and when she tried to help him change them, he became violent and loud. He swung his arms, squeezed her, hit her in the forehaead and tried to bite her. - on 3/19/21 Tenant #1 had urine on his pants after a nap and when staff assisted him in changing, he hit her in the face, arms and stomach. He attempted to bite her but she got out of the way. Tenant #1 spit in her mask and said he was going to kill her. He grabbed her wrists and squeezed them. He also yelled curse words at her. - Tenant #1 was upset and acted like he was going to shoot a caregiver on 3/22/21. He grabbed her forearms and shook them. He urinated on the floor. Tenant #1 got in an altercation with Tenant #2 and called him a name. - on 3/24/21 Tenant #1 antagonized Tenant #2 four times by calling him names and raising his fist at him. - Tenant #1 threatened he would break the staffs' neck and bones on 3/28/21.	A 160		

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A 160	Continued From page 5 The Executive Director, Health Services Director and Residential Care Coordinator confirmed these findings on 3/30/21 at 5:00 PM. The Executive Director stated he had been unaware of the frequency and intensity of the tenant's actions.	A 160		
A 365	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care 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 with a significant change for 3 of 5 current (Tenants #1, #2, #3) and 1 of 1 former (Tenant C1) tenants reviewed. Findings follow: 1) Review of charting notes and incident reports on 3/29/21 revealed Tenant #1 walked past Tenant #4 on 3/7/21, grabbed her shoulders and shook her. On 3/9/21, Tenant #1 urinated on the table and floor. He raised his fists to Tenant #2 and grabbed the staff who stepped in to break up the altercation. He told a staff member who assisted him in the bathroom he would tear her guts out. Tenant #2 frequently spit on the ground and ignored staff requests to stop. Tenant #1 grabbed two staff members by their arms on 3/10/21, and paced around the program spitting on the floor. Staff noted from 4:00 PM - 7:00 PM,	A 365	The service plans will be updated with intervention from the Health Service Director and the Resident Care Coordinator when a resident has a reoccurring behavior and need addressed, resident returns to the community from hospital and higher level of care, when a resident has frequent incontinence, prior to the resident signing the occupancy agreement, 30 days of the resident's occupancy, significant change occurs, and annually. The service plan shall be individualized to the resident needs, preferences, services and cares pertaining to occupancy agreement, and other service providers. Tenants who are unable to plan their own activities, including residents with dementia, a list of person-centered planned and spontaneous activities based on the resident's abilities and personal interests. Completed by 6/7/2021	

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A 365	Continued From page 6 Tenant #1 spit on the floor 35 times. When asked to stop he yelled. On 3/11/21, Tenant #1 yelled at staff and tenants. He hit and spit on staff when they helped him go to the restroom. Tenant #1 yelled at three tenants on 3/12/21. Staff attempted to take Tenant #1 to the bathroom many times on 3/13/21 without luck after seeing him attempt to urinate in inappropriate areas. He eventually urinated in front of the bathroom door in the hall. Tenant #1 acted as if he was going to put his hands around Tenant #4's neck but staff intervened and he grabbed her arms and then tried to bite her finger. He also spit on staff, the floor, railings, tables and chairs. Staff noticed Tenant #1's pants were wet on 3/15/21 and when she tried to help him change them, he became violent and loud. He swung his arms and squeezed her. Tenant #1 hit staff in the forehead and tried to bite her. Later he also yelled at two tenants. Staff noted Tenant #1 spit 35 times on the 2nd shift that day. On 3/19/21, Tenant #1 had urine on his pants after a nap and when staff assisted him in changing, he began hitting her in the face, arms and stomach. He attempted to bite her but she got out of the way. Tenant #1 spit in her mask and said he was going to kill her. He grabbed her wrists and squeezed them. He also yelled curse words at her. On 3/22/21, Tenant #1 was upset and acted like he was going to shoot a caregiver. He grabbed her forearms and shook them. He also urinated on the floor. Tenant #1 got in an altercation with Tenant #2 and called him a name. Tenant #1 antagonized Tenant #2 four times on 3/24/21 by calling him names and raising his fist at him. On 3/28/21, Tenant #1 threatened he would break the staffs' neck and bones. Tenant #1's Resident Service Plan dated 3/4/21 identified his behavior/mood symptoms would be	A 365		

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A 365	Continued From page 7	A 365		

managed by staff. The plan noted Tenant #1 became agitated and frustrated because he could not remember things. He became verbally and physically aggressive toward staff and others. Staff were to direct Tenant #1 from trigger points and over stimulated environments and offer a calm approach. His plan identified he urinated in inappropriate places at times because he urinated outside when he lived on a farm. He required a lot of cueing from staff when using the restroom. Staff were to show Tenant #1 where the toilet was located in his room and to assist with changing his incontinence undergarments when soiled. Tenant #1's Resident Service Plan was not updated to address the increased physical and verbal aggression which occurred during the month of March. The plan did not identify interventions staff were to take when Tenant #1 spit within the building. The plan did not address actions staff could take when Tenant #1 became frustrated and aggressive when being assisted with toileting.

On 3/31/21 at 5:00, the Executive Director, Health Services Director and Residential Care Coordinator (RCC) confirmed these findings and stated Tenant #1's dementia had worsened over the last few weeks which may have contributed to these behaviors.

2) Review of charting notes and incident reports revealed Tenant #2 pushed Tenant #1 after being called names on 1/24/21. On 2/12/21, Tenant #2 was agitated, tried to hit others and grabbed staff's wrist when she blocked him from hitting other tenants. Tenant #2 was verbally aggressive with Tenant #1 on 2/13/21 and they raised their fists at each other. On 2/17/21, Tenant #2 had verbal disagreements with others. Tenant #2

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A 365	Continued From page 8 punched Tenant #1 on 2/18/21. They argued throughout the day and later he punched the same tenant in the mouth. On 2/25/21, Tenant #2 swung his arm at a caregiver and punched the wall. The following day, Tenant #2 broke items, threatened to hit staff and punched the wall three times. On 3/1/21, Tenant #2 had a verbal argument with a caregiver. Tenant #2 was verbally aggressive on 3/2/21. On 3/3/21, Tenant #2 grabbed a staff person's rear end. Tenant #2 hit a caregiver and tried to provoke Tenant #1 on 3/9/21. On 3/10/21, Tenant #2 hit Tenant #6 in the back. Tenant #2 had three arguments with Tenant #1 on 3/12/21. Tenant #2 tried to get out the door on 3/21/21 and also punched the door. Tenant #4 was confused and tried to enter Tenant #2's apartment on 3/24/21 and 3/25/21. Tenant #2 grabbed Tenant #4 by the arm and pulled her away each day. On 3/25/21, Tenant #2 punched Tenant #1. The program provided Tenant #2 with a 30-day Move Out Notice on 3/26/21 as he had engaged in behavior or actions that had repeatedly and substantially interfered with the rights, health or safety of residents of others. Tenant #2 had a 30-day review of his service plan dated 2/14/21. The plan identified Tenant #2 had behavior problems concerning another tenant who cussed and yelled. A few times the other tenant and Tenant #2 yelled at each other and raised their fists at each other. Staff were to try to keep the tenants separated as much as possible. The plan was not updated to address his verbal or physical aggression towards other tenants and staff which resulted in him being being given a 30-day notice to leave the program. 3) A review of charting notes for Tenant #4	A 365		

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A 365	Continued From page 9 revealed on 1/23/21 at 1:55 PM, a caregiver heard a loud noise in the hallway. She went to check and found Tenant #4 laying on the floor in her doorway. Tenant #4's head was laying on her glasses on the floor, with her arm under her. She had a raised area on her temple. During the afternoon, Tenant #4 kept falling asleep and waking up more confused and was unable to sit up in a chair without slipping out of it. At 3:39 PM, a caregiver called the RCC with an update. The RCC called Tenant #4's family and it was decided to send her to the emergency department for an evaluation. Tenant #4's family called back to report Tenant #4 had an intracranial hemorrhage/epidural bleed. Tenant #4 was admitted to the hospital. The program was notified Tenant #4 would be returning on 1/25/21 and had tested positive for Covid-19. The facility picked her up at 9:40 AM. Tenant #4 was noted to be very confused and mumbled when she talked, but was independent with ambulation. Additional falls were noted on 1/25/21 (2 falls) and 1/26/21. The hospice nurse completed an assessment of Tenant #4 on 1/27/21. He noted staff reported Tenant #4 had increased weakness, confusion and slurred speech following the fall on 1/23/21. She required more assistance with cares due to the fall. Staff reported the tenant was frequently incontinent of bowel and bladder prior to the fall. Staff reported Tenant #4 was eating less than 50% of her meals in the two months prior to the fall. When the nurse arrived, Tenant #4 was sitting in a wheelchair. Staff told him Tenant #4 had fallen a short time before his arrival. He noted it was possible she hit her head as she was bleeding from her nose. Tenant #4 had her eyes open and was able to track the nurse's movements but was unable to participate in a neurological assessment due to her garbled	A 365		

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speech and inability to follow commands. The nurse noted the discharge report from the hospital indicated Tenant #4 was able to answer simple questions upon discharge but she was unable to do so at that time. Tenant #4 was unable to stand unsupported.

Tenant #4 had an episode of incontinence on 3/10/21. The RCC contacted Tenant #4's daughter on that date and notified her Tenant #4 was having episodes of incontinence and suggested she bring in some incontinence products. On 3/23/21, A caregiver found used incontinence products in Tenant #4's dresser drawers.

Tenant #4's Resident Service Plan dated 9/2/20 identified she ambulated and transferred independently. She was at low risk for falls. The plan noted Tenant #4 was continent of bowel and bladder and independent with all of her restroom needs. She was able to understand others and be understood by others. Tenant #4 was independent with dressing. There was no mention of Tenant #4 needing prompting to eat or eating less food than normal.

On 3/31/21 at 5:00 PM, the Executive Director, Health Services Director and Residential Care Coordinator confirmed Tenant #4's Resident Service Plan was not updated when she had changes in her condition

4) A review of Tenant C1's record revealed an Incident Report and Investigation Worksheet dated 12/8/20. Tenant C1 was found laying on the floor underneath the sink. She didn't know how long she had been laying there and was not wearing her emergency pendant. She complained of her right leg hurting and already had bruises.

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SUNNYBROOK OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

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A 365	Continued From page 11 Tenant C1's closet door was broken as if she had fallen into it. A charting note dated 12/8/20 revealed Tenant C1 had a right hip fracture as a result of the incident which required surgery. Tenant C1 received treatment at a skilled nursing facility following the surgery and returned to the program on 1/12/21. A review of Charting Notes revealed staff assisted Tenant C1 to the bathroom on 1/14/21 and left the room to get wipes. The tenant attempted to get up on her own and fell to the ground. She complained of pain to the right hip near the sight of her recent injury. On 1/16/21, it was noted staff attempted multiple times to get Tenant C1 up but she would not allow anyone to move her or help her up. She refused to go to the bathroom. Tenant C1 was found by a caregiver sitting on the floor in front of her recliner on 1/30/21. She did not know what happened. The Resident Care Coordinator (RCC) documented she would place an alarm in whatever chair Tenant C1 was sitting in. On 2/1/21, Tenant C1 was noted to have a stage 2 pressure ulcer on her right hip measuring 2 x 1.5 cm with scant drainage. There were no signs of infection. On 2/2/21 at 7:00 PM, staff found Tenant C1 sitting on her bottom on the floor in front of her wheelchair. Tenant C1 had been sitting in her wheelchair and attempted to self-transfer without pushing her pendant. She was noted to have a small scabbed area around the coccyx area measuring 0.2 cm. x 0.2 cm. on 2/3/21. Foam was placed to provide comfort and protection, but there was no drainage or any other signs of infection noted. Tenant C1 had an appointment with her doctor on 2/4/21 and a pressure relieving cushion was ordered for her chair due to her pressure ulcer. A referral was also made to the wound clinic. On 2/6/21 at 10:40 PM, Tenant C1's bed alarm sounded. When staff	A 365		

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
	S0208	A. BUILDING: _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

(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 365	Continued From page 12 checked on her, she was observed sitting on the floor leaning against her open room door. She reported falling out of bed and crawling to the doorway. Her wheeled walker was sitting next to her. She denied pain. On 2/8/21, an appointment was scheduled for Tenant C1 at the wound clinic for 2/16/21. Tenant C1's sore on her right hip was documented to have white around it with black spotting and Tenant #4 reported pain in her hip and bottom. The hip wound had brownish drainage with a red area around it on 2/9/21. There was also green drainage around the scab according to the note. The hip wound remained the same size but had not improved according to a note dated 2/10/20. The wound to the coccyx had improved. Two tenants reported to staff Tenant C1 was on the floor on 2/11/21. She told staff her body felt tight so she tried to stand on her own. She complained of pain to the left hip and right waist. The RCC faxed Tenant C1's doctor to inform him the tenant was refusing most of her medication on 2/12/21. Tenant C1 sometimes took 2-3 pills and then refused the rest of her medication. Tenant C1 refused all of her medication at times. Tenant C1 was found on the floor at 7:00 PM. She reported she raised her lift chair too high and fell out, hitting her head on a decorative cement bird on her floor. When caregivers entered her room, she complained of pain in her hips. Tenant C1 was sent to the hospital for an evaluation. She had a left and right pubic rami fracture and thoracic fractures. Tenant C1 was transferred to a higher level of care. A review of Tenant C1's Resident Service Plan dated 1/12/21 revealed while changes had been made in an effort to decrease falls, it was not updated to address wound care or medication refusal.	A 365		

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 365	Continued From page 13 The Executive Director, Health Services Director and RCC confirmed these findings on 3/31/21 at 5:00 PM.	A 365		