

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2021
NAME OF PROVIDER OR SUPPLIER SUNSET PARK PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>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.</p> <p>General Population</p> <p>Number of tenants without cognitive disorder: 51</p> <p>Number of tenants with cognitive disorder: 3</p> <p>Memory Care Unit</p> <p>Number of tenants without cognitive disorder: 0</p> <p>Number of tenants with cognitive disorder: 9</p> <p>Total Census: 63</p> <p>The investigation of Incidents #97317-I, #97631-I and Complaint #97858-C resulted in the following regulatory insufficiencies:</p>	A 000		
A 135	<p>481-69.22(1) Evaluation of Tenant</p> <p>69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation</p>	A 135	<p><i>Plan of Correct is attached</i></p> <p><i>DD</i></p>	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 135	<p>Continued From page 1</p> <p>shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the Program failed to complete an initial evaluation prior to signing the occupancy agreement for 1 of 1 tenants reviewed admitted since 4-1-21 (Tenant #2). Findings follow:</p> <p>1. Record review on 6-22-21 of Tenant #2's file revealed an admission date of 4-14-21. The Occupancy Agreement was signed on 4-13-21 at 4:00 p.m. by the Assistant Director and Tenant #2's legal representative. The Occupancy Agreement indicated the Program agreed to provide the services indicated starting on 4-14-21 at 1:30 p.m.</p> <p>Continued record review revealed the Comprehensive Assessment, the Short Portable Mental Status Questionnaire and Global Deterioration Scale were all dated as completed on 4-14-21, which was after the occupancy agreement was signed.</p> <p>2. An interview completed on 7-12-21 at 10:51 a.m. with the Director and Healthcare Coordinator confirmed the above finding.</p>	A 135		
A 355	481-69.26(2) Service Plans	A 355		
	69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with			

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A 355	<p>Continued From page 2</p> <p>the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the Program failed to develop a service plan prior to signing the occupancy agreement for 1 of 1 tenants reviewed admitted since 4-1-21 (Tenant #2). Findings follow:</p> <p>1. On 6-22-21 review of Tenant #2's file revealed an admission date of 4-14-21. The Occupancy Agreement was signed on 4-13-21 at 4:00 by the Assistant Director and Tenant #2's legal representative. The Occupancy Agreement indicated the Program agreed to provide the services indicated starting on 4-14-21 at 1:30 p.m.</p> <p>Tenant #2's service plan was dated 4-14-21 and signed by the Healthcare Coordinator, Director and Tenant #2's legal representative on 4-14-21, which was after the occupancy agreement was signed.</p> <p>2. An interview completed on 7-12-21 at 10:51 a.m. with the Director and Healthcare Coordinator confirmed the above finding.</p>	A 355		
A 395	481-69.26(4)a Service Plans	A 395		
	69.26(4) The service plan shall be individualized and shall indicate, at a minimum:			

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A 395	<p>Continued From page 3</p> <p>a. The tenant's identified needs and preferences for assistance</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans reflected the identified needs of 2 of 5 tenants reviewed (Tenants #2, #3). Findings follow:</p> <p>1. Review of an incident report dated 5-24-21 indicated at approximately 7:45 a.m. the Healthcare Coordinator arrived at the building and parked in the upper employee parking. He noticed a man lying on the ground next to the building, went over to him and realized it was Tenant #2. There was no apical pulse present, Tenant #2 was not breathing and was cool to the touch. He ran to the door and told the Assistant Director to call 911. The police took over and Tenant #2 was pronounced dead at the Program.</p> <p>Review of a written statement by the Assistant Director dated 5-24-21 reflected at 7:43 a.m. on 5-24-21 she received a call from Tenant #2's legal representative regarding a disturbing phone call with Tenant #2. He said if he could not live with his girlfriend he was going to jump out of the window. When the AD received the call she was arriving at work. She sent Staff B to check on him and when the check was completed Staff B could not find Tenant #2. The AD went to his apartment to check and noticed the bedroom window was open and the screen was missing. She went to the first floor and out the door and met the Healthcare Coordinator at the door. He said to call 911 because Tenant #2 was outside on the ground. She called 911 and returned outside with</p>	A 395		

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A 395	<p>Continued From page 4</p> <p>the Healthcare Coordinator. Family was notified of his death at 8:39 a.m.</p> <p>Review of Tenant #2's file on 6-22-21 the tenant was admitted to a local hospital on 4-8-21 and then discharged to the Program on 4-14-21. Tenant #2 was placed in the memory care unit initially and then was transferred to the apartments outside of the memory care unit (general population) on 4-20-21. Tenant #2 resided there until his death on 5-24-21. Tenant #2's diagnoses included vascular dementia without behavioral disturbance, major depressive disorder and anxiety. Tenant #2 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline.</p> <p>A review of hospital records indicated Tenant #2 was admitted from his doctor's office on 4-8-21. A psychiatric consultation was requested. Tenant #2 had a history of chronic anxiety. He denied suicidal thoughts; however, Tenant #2 had cashed out his life insurance policy the day before admission, tens of thousands of dollars could not be accounted for that had been spent in the past few months and he had purchased four guns and ammunition. Family described Tenant #2 as more irritable in the recent months, which was a change. He had mentioned a friend who had committed suicide after she was told to stop driving. In past months he was also very upset with a family member and referenced a violent act towards that person. Tenant #2's family were fearful he might harm himself but also use the weapons to harm others. The records indicated Tenant #2 was not safe to return home, even with caregivers. There was a "significant risk" he could use weapons and the home environment was not safe. Recommended placement was in a locked memory care unit, either assisted living or</p>	A 395		

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A 395	<p>Continued From page 5</p> <p>long-term care.</p> <p>Continued record review revealed service plans were developed on 4-14-21 (initial service plan), on 4-20-21 (move out of the memory care unit) and on 5-12-21 (30 day evaluation). The service plans did not reflect the safety concerns provided in the hospital records or any possible needed interventions.</p> <p>2. Review of Tenant #3's file on 6-22-21 revealed diagnoses including dementia with behavioral disturbance. Tenant #3 was staged at a six on the GDS, which indicated severe cognitive decline. Progress Notes indicated the following:</p> <ul style="list-style-type: none"> - On 4-9-21 it was noted staff assisted Tenant #3 with dressing after a shower and she got mad and punched staff in the throat. - On 4-10-21 it was noted Tenant #3 was eating food out of the garbage and staff asked her to put it back in the garbage. She refused, threw it on the floor and when staff bent over to pick it up, she pushed staff to the floor. - On 4-11-21 it was noted Tenant #3 was sent to the emergency room (ER) due to recent aggression and agitation. - On 4-15-21 it was noted Tenant #3's family took her out on a drive and she refused to come back into the building. She came back in after approximately 40 minutes. - On 4-20-21 it was noted Tenant #3 woke up kicking and swinging at staff trying to get her up. - On 4-22-21 it was noted an as needed (PRN) medication was ineffective and Tenant #3 was still yelling, pacing back and forth and would not sit down. - On 5-5-21 it was noted Tenant #3 struck staff alongside of her face when attempting to get her up and out of bed. - On 5-6-21 it was noted Tenant #3 was 	A 395		

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A 395	<p>Continued From page 6</p> <p>incontinent in her bed and refused four attempts to get her up and changed by three different staff, including a nurse. Staff was instructed to attempt every 30 minutes until successful.</p> <ul style="list-style-type: none"> - On 5-6-21 it was noted staff heard a verbal altercation and when they came out they saw Tenant #3 grabbing another tenant by the shirt. The other tenant removed her hand and her thumb nail cut Tenant #3's right thumb at the base of the finger. Staff separated the two tenants. No injuries were noted except the small cut to Tenant #3's finger. - On 5-7-21 it was noted Tenant #3 attempted to strike a staff member while assisting her with cares. Later she became upset with a tenant and swung in the air at the tenant but did not hit the tenant. - On 5-10-21 it was noted two tenants were upset with Tenant #3's interactions with the dog, which then upset Tenant #3. She attempted to rip the remote cord from the recliner and when staff attempted to intervene she became aggressive. - On 5-18-21 it was noted physical therapy (PT) and occupational therapy (OT) were discontinued. - On 5-24-21 it was noted another tenant claimed Tenant #3 punched her in the chest. The other tenant had no marks and said she not harmed. Tenant #3 went outside where staff attempted to calm her and she pinched, scratched, hit and kicked staff. - On 6-2-21 it was noted Tenant #3 went to hit another tenant and staff got between the two. Tenant #3 punched staff numerous times in the back. Tenant #3 began to cry, said she did not understand what she had just done and that she should just "kill herself" for what she did. - On 6-5-21 it was noted Tenant #3 attempted to slap another tenant in the face. Staff was able to deflect the slap and she slapped the other tenant 	A 395		

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A 395	<p>Continued From page 7</p> <p>in the shoulder instead. She then hit staff with an open hand, hit and pinched. Tenant #3 was transported to the hospital and returned from the ER that day.</p> <p>- On 6-5-21 it was noted Tenant #3 tried to force another tenant out of the way to get out her sliding patio door. Tenant #3 picked up a door stop, which was a pole and attempted to hit staff with it. Staff took the pole away and guided Tenant #3 out of the other tenant's apartment. Tenant #3 became aggressive and scratched staff.</p> <p>Tenant #3's service plan dated 4-15-21 noted if she refused showers or medications, different staff were to re-approach to attempt to complete the task. The plan indicated she had increased behaviors with urinary tract infections. There was no specific reference to physical aggression towards staff and tenants or any interventions in place for when these behaviors occurred. The service plan also included PT and OT services, despite discharge from the therapy services.</p> <p>3. When interviewed on 7-12-21 at 10:51 a.m. the Healthcare Coordinator said Tenant #2 did not display any of the behaviors noted in the hospital documents while at the Program. Tenant #3's service plan reflected to give her space (regarding behaviors).</p>	A 395		
A 870	481-69.39(4) Respite Care Services	A 870		
	69.39(4) Written direction to staff. The program nurse shall document the care needs of the respite care individual based on the assessment conducted pursuant to subrule 69.39(3) and provide the documentation to staff.			

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A 870	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure documented care needs were followed by staff for 1 of 1 respite care individuals reviewed (Tenant #1). Findings follow:</p> <p>Review of an incident report dated 3-30-21 at 2:45 p.m. revealed Tenant #1 was noted walking outside independently. Tenant #1's spouse arrived to the building and accompanied her back to the apartment. An assessment was completed and vitals were checked. Tenant #1 denied pain and when asked why she went outside indicated it was nice outside and she wanted to go for a walk. Immediate action taken included for activity staff to escort her to and from activities. The weather was sunny and 59 degrees.</p> <p>Review of Tenant #1's file on 6-22-21 revealed she was admitted for respite services on 3-29-21. She was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline and she had a diagnosis of Alzheimer's disease with late onset.</p> <p>The service plan dated 3-29-21 reflected Tenant #1 was on safety checks every hour and an escort was needed to and from activities and the dining room.</p> <p>The Task Schedule reflected visual checks were to be completed every hour for Tenant #1. A visual check was completed on 3-30-21 at 12:48 p.m. and the next recorded check on 3-30-21 was at 5:15 p.m. The check for 1:00 p.m. was recorded at 12:48 p.m., the check for 2:00 p.m. was recorded at 5:15 p.m., the check for 3:00 p.m. was recorded at 5:18 p.m., the check for</p>		A 870	

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A 870	<p>Continued From page 9</p> <p>4:00 p.m. was recorded at 5:19 p.m. It could not be determined if hourly checks were actually completed as 2:00, 3:00 and 4:00 checks were all documented after 5:15 p.m.</p> <p>When interviewed on 6-24-21 at 9:45 a.m. the Healthcare Coordinator said he was going from the memory care unit to his office and saw Tenant #1 on the first floor by the elevator door. She had just attended an activity. He went to his office and was on the telephone when he looked out his window and saw Tenant #1. He sent Staff A to go outside and bring her in. Tenant #1 was assessed, there were no injuries and she reported she had gone for a walk as it was nice outside. He estimated Tenant #1 was gone approximatley three minutes. Tenant #1 was dressed appropriately for the weather and had her purse with her.</p> <p>A typed statement provided by the Healthcare Coordinator dated 3-30-21 revealed Tenant #1 was last seen getting on the elevator with other tenants, leaving an activity on the first floor. There was no indication she wanted to go outside and she was laughing and having a good time with the other tenants. He walked to his office, sat down and answered the phone. He then observed Tenant #1 walking on the sidewalk. The statement indicated he was not sure how she got out of the building, however, she was observed approximatley 15 feet from the edge of the building, waiting on the sidewalk in front of the parked cars (towards the street). He was on the phone and sent Staff A (licensed practical nurse) to check on her and bring her back into the building. Staff A reached Tenant #1 just as she turned the corner as the sidewalk turned to go uphill.</p>	A 870		

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A 870	<p>Continued From page 10</p> <p>When interviewed on 6-23-21 at 3:22 p.m. Staff A revealed she and the Healthcare Coordinator had an office that faced the parking lot. The Healthcare Coordinator saw Tenant #1 first and asked Staff A to go after her. Staff A went upstairs and out of the front door and saw Tenant #1 going up the hill towards the street. Tenant #1 was still on the grounds of the Program. Staff A and Tenant #1 walked hand in hand towards the building. Tenant #1 told Staff A it was nice out and she wanted to go for a walk. The Life Enrichment Coordinator then came out, took the tenant's other hand and took over from there.</p> <p>When interviewed on 6-23-21 at 4:13 p.m. the Life Enrichment Coordinator revealed Tenant #1 had come down for the Rosary at 1:00 p.m. and then stayed for a music activity. Both activities were held in the activity room (first floor). When music was done, Tenant #1 was with a group of tenants getting on the elevator. She last saw Tenant #1 at 2:30 p.m. She heard someone running up the steps and learned it was Staff A, who was on her way out of the building. The Life Enrichment Coordinator went to the front door and saw Staff A with Tenant #1, approximatley two thirds of the way down the sidewalk and they were returning to the building. Tenant #1 was brought back into the building. The weather was pleasant and sunny. Tenant #1 was dressed in a shirt, sweater, pants and shoes. She estimated from when she saw Tenant #1 by the elevator to when Staff A was with her outside was less than five minutes.</p> <p>When interviewed on 6-24-21 at 11:09 a.m. the Director revealed Tenant #1 was in a group activity on first floor, went to the second floor, left the main elevator and went out the door. It was the only way she would have been able to leave.</p>	A 870		

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A 870	<p>Continued From page 11</p> <p>He was told the Healthcare Coordinator recognized Tenant #1 was out of the building and Staff A went to get her and redirected her back to the building. Tenant #1's spouse was also walking into the building. The Director estimated Tenant #1 was gone for approximately one to two minutes before observed. She returned to the building and an assessment was completed. The Director said after the activity the Life Enrichment Coordinator either had a telephone call or another tenant issue. Either direct care staff or activity staff could assist with escorting tenants to and from activities.</p> <p>When observed on 6-23-21 at 10:30 a.m. the possible terrain Tenant #1 covered was sidewalk, parking lot and grass. The distance traveled by foot from the building to where Tenant #1 was found was approximatley 105 steps per phone pedometer. The time it took to travel the distance by foot was 1:24:07.</p> <p>When observed on 6-24-21 at 10:45 a.m. if one approached the front door, it would not open unless the button on the right side of the door was pushed first to exit. When the button was pushed to exit the door slid open and staff's pager reflected the door was open. The door would not shut or close if still being picked up by sensor. Once out of the sensor area the door closed.</p> <p>The State Climatologist indicated the weather conditions on 3-30-21 at 2:45 p.m. were as follows: temperature was 46 degrees, winds were from the west at 21 miles per hour (mph), with 31 mph gusts. Relative humidity was 36%, there was no precipitation and low cloud cover. The wind chill was 38 degrees.</p>	A 870		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2021
NAME OF PROVIDER OR SUPPLIER SUNSET PARK PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 870	<p>Continued From page 12</p> <p>An interview completed on 7-12-21 at 10:51 a.m. with the Director and Healthcare Coordinator confirmed Tenant #1's service plan at the time of the elopement reflected escorts to and from activities and meals and one hour visual checks.</p> <p>In summary, Tenant #1 was admitted for respite services on 3-29-21 and had a service plan that reflected hourly visual checks and escorts to and from meals and activities. Tenant #1, who had moderate cognitive decline, attended an activity on the second day of the respite stay, left the building and was observed by staff outside the building. During the time of Tenant #1's elopement the scheduled visual checks that were to be provided per the service plan were not documented hourly. The escort from the activity was also not provided as indicated on the service plan as Tenant #1 left the activity without staff.</p>	A 870		

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 6/21/2021 and 8/26/2021 Self-Report x 2 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: 10/27/2021

Complaint Intake #: Investigation of Incidents #97317-I, #97631-I and Complaint #97858-C

Plan of Correction (POC) Submitted For:

- Investigation Date: 6/21/2021 and 8/26/2021
- Monitors: [REDACTED]

POC: 481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete an initial evaluation prior to signing the occupancy agreement for 1 of 1 tenants reviewed admitted since 4-1-21

Program POC:

1. Elements detailing how this was corrected for residents:
 - a. Community has completed re-training for Director, Assistant Director and Health Care Coordinator regarding

✓ 10/28/21

regulations regarding timing of signature compliance with evaluations, service plan, and Occupancy Agreements.

2. Actions program taking to protect tenants in similar situations:
 - a. JSL team re-educated Director, Assistant Director and Health Care Coordinator regarding regulations regarding timing of signature compliance with evaluations, service plan, and Occupancy Agreements.
3. Measures taken to ensure problem does not recur:
 - a. Community has completed re-training for Director, Assistant Director and Health Care Coordinator regarding regulations regarding timing of signature compliance with evaluations, service plan, and Occupancy Agreements.
 - b. Increased communication between the community leaders will assure this does not happen going forward
4. Program plans to monitor performance to ensure compliance:
 - a. Continued monitoring of effective communication between the community leaders will be audited as needed, daily, weekly, monthly as determined by the Community Director or designee.

POC: 481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.

Program POC:

1. Elements detailing how this was corrected for residents:
 - a. Community has completed re-training for Director, Assistant Director and Health Care Coordinator regarding regulations regarding timing of signature compliance with evaluations, service plan, and Occupancy Agreements.
2. Actions program taking to protect tenants in similar situations:
 - a. JSL team re-educated Director, Assistant Director and Health Care Coordinator regarding regulations regarding timing of signature compliance with evaluations, service plan, and Occupancy Agreements.
3. Measures taken to ensure problem does not recur:
 - a. Community has completed re-training for Director, Assistant Director and Health Care Coordinator regarding regulations regarding timing of signature compliance with evaluations, service plan, and Occupancy Agreements.

- b. Increased communication between the community leaders will assure this does not happen going forward
- 4. Program plans to monitor performance to ensure compliance:
 - a. Continued monitoring of effective communication between the community leaders will be audited as needed, daily, weekly, monthly as determined by the Community Director or designee.

POC: 481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans reflected the identified needs of 2 of 5 tenants reviewed (Tenants #2, #3)

Program POC:

- 1. Elements detailing how this was corrected for residents:
 - a. Community has completed re-training for the Director, Assistant Director and Health Care Coordinator regarding increasing behavioral interventions for residents as needed.
- 2. Actions program taking to protect tenants in similar situations:
 - a. JSL team re-educated Director, Assistant Director and Health Care Coordinator regarding increasing behavioral interventions for residents as needed.
- 3. Measures taken to ensure problem does not recur:
 - a. Community has completed re-training for Director, Assistant Director and Health Care Coordinator regarding increasing behavioral interventions for residents as needed.
 - b. Staff education completed with current direct staff to discuss increased interventions added to resident's ISP's that have behaviors.
- 4. Program plans to monitor performance to ensure compliance:
 - a. Continued monitoring of resident's behaviors and interventions needed will be audited as needed, daily, weekly, monthly as determined by the Community Director or designee.

POC: 481-69.39(4) Respite Care Services 69.39(4) Written direction to staff. The program nurse shall document the care needs of the respite care individual based on the assessment conducted pursuant to subrule 69.39(3) and provide the documentation to staff. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure documented care needs were followed by staff for 1 of 1 respite care individuals reviewed

Program POC:

1. Elements detailing how this was corrected for residents:
 - a. Community will complete re-training for direct care staff and community coordinators regarding resident specific tasks and interventions/tasks for providing escorts to/from activities by 11/11/2021.
2. Actions program taking to protect tenants in similar situations:
 - a. Community will complete re-training for direct care staff and community coordinators regarding resident specific tasks and interventions/tasks for providing escorts to/from activities by 11/11/2021.
3. Measures taken to ensure problem does not recur:
 - a. Community will complete re-training for direct care staff and community coordinators regarding resident specific tasks and interventions/tasks for providing escorts to/from activities by 11/11/2021.
4. Program plans to monitor performance to ensure compliance:
 - a. Continued monitoring of residents service plans/tasks and interventions needed will be audited as needed, daily, weekly, monthly as determined by the Community Director 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