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 07/02/2026

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: 37 Number of tenants with cognitive impairment: 6 Total census: 43 Regulatory insufficiencies were cited during the investigation of Mandatory Report #132049-M, Abuse Report #132065-A, and Complaint #132191-C.	A 000	See attached POC 10/23/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) 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 policies related to incident reports and tenant illness for 2 out of 4 tenants (Tenant #1, Tenant #2). Findings follow: 1. Record review on 6/01/26 revealed an incident report dated 5/23/26 and nurse's notes dated 5/23/26 for Tenant #2. According to the reports, at 1:09 a.m., Staff H received a call from Staff G stating that Tenant #2 was found outside on the next street over from the Program by emergency medical services (EMS) staff. Staff G reported Tenant #2 complained of back pain to EMS staff and was taken to the hospital for evaluation. A nurse's note dated 5/26/26 by Staff H indicated	A 116		

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A 116	Continued From page 1 Tenant #2 was in the hospital and was being treated for a urinary tract infection. Tenant #2 returned to the Program on 5/27/26. Tenant #2's last Global Deterioration Scale (GDS) score prior to 5/23/26 was a 2, indicating mild cognitive decline on 11/29/25. Tenant #2's service plan on 5/23/26 indicated Tenant #2 had mild cognitive impairment and no concerns with wandering. When interviewed on 6/02/26 at 10:42 a.m., Staff G confirmed she arrived for the overnight shift at 10:00 p.m. on 5/22/26. Staff G reported Tenant #2 came down to the main sitting area on the second floor where the main exit door is located. Tenant #2 reported her back hurt and she wanted staff to call someone. Staff G called Staff H, who was on-call. Staff H asked Staff G if she could administer pain medication, which she could not. Staff H then asked Staff G to call the Assistant Director, who lived nearby, to administer the medication. Staff G confirmed the Assistant Director came to the Program and administered pain medication to Tenant #2 for her back. Staff G reported that Tenant #2 attempted to type the code on the exit door and stated she needed to go several times after the Assistant Director left. Staff G indicated a call light alarmed for a different tenant who required assistance with toileting. Staff G confirmed she ensured Tenant #2 was safe and away from the front door, and then went to answer the call light sometime after 11:00 p.m. Staff G believed she was gone from the common area for around 7 to 10 minutes. Staff G confirmed an alarm sounded upon her return from answering the call light. Staff G stated her iPad indicated the side door alarm sounded, but noted she had no idea which door the "side door" was. Staff G then noticed Tenant #2 was gone from the common area. Staff G indicated she checked Tenant #2's apartment, all floors of	A 116		

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the building, and searched outside around the premises with no luck. Staff G reported that her iPad eventually indicated a page from Tenant #2's pendant. Staff G confirmed that shortly after, EMS staff called the Program and reported they had found Tenant #2 on the next street over from the Program. Staff G reported EMS staff indicated Tenant #2 told them her back hurt and she needed help. The EMS staff took Tenant #2 to the emergency room for assessment. Staff G confirmed a police officer came to the building and talked to her, firefighters called her to ask questions, and hospital staff called her to ask questions. Staff G stated she then called the Assistant Administrator to report what happened.

When interviewed on 6/02/26 at 9:57 a.m., the Assistant Director confirmed she came to the Program on 5/22/26 at around 11:00 p.m. to administer pain medication to Tenant #2 due to back pain. The Assistant Director asked Tenant #2 what hurt; Tenant #2 indicated her feet and back hurt and took her shoes and socks off. The Assistant Director told Staff G to watch Tenant #2 and, if she had no pain relief in an hour, to call the on-call staff. The Assistant Director confirmed she was not certain of the exact time, but later in the early morning of 5/23/26, she received a call from Staff G reporting Tenant #2 had been taken to the emergency room for evaluation by EMS staff because she was found knocking on a neighboring house the next street over from the Program, saying her back hurt.

When interviewed on 6/02/26 at 12:15 p.m., the Assistant Director confirmed she personally trained Staff G on the alarm systems. Staff G was given a tour of the building and shown how the alarms appeared on the iPad when activated. The Assistant Director confirmed Staff G never called

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her or the on-call staff upon the alarm sounding and the discovery that Tenant #2 was missing. The Assistant Director added that Staff G received disciplinary action concerning the incident.

When interviewed on 6/02/26 at 3:05 p.m., Staff H confirmed she received a call from Staff G sometime after 1:00 a.m. on 5/23/26 to report Tenant #2 was taken to the hospital by EMS staff for evaluation because she was discovered on the next street over from the Program. Staff H confirmed Staff G had called her regarding Tenant #2 and back pain earlier in the night, but did not recall Staff G calling to report an alarm sounding or the fact that Tenant #2 was missing.

Record review of Program door alarms on 6/02/26 revealed staff responded to a call light by a different tenant on 5/22/26 at 11:35 p.m. The alarm record revealed the main side door-which is an exit doorway in the stairwell that exits the building right beside the front door of the Program-alarmed at 11:41 p.m. The alarm record showed the front door was used multiple times after the side door alarm until 12:38 a.m., when Tenant #2's pendant alerted on Staff G's iPad.

Record review of Program policies on 6/03/26 revealed an Incident Report Policy. The policy indicated the following: "Staff will notify the Nurse or designee if a tenant has fallen or any unusual event occurs." Further record review of personnel documents in Staff G's record revealed Staff G received disciplinary action for a delayed response to the door alarm and for failing to contact the Director or his designee immediately upon the discovery of an unaccounted-for tenant.

When interviewed on 6/03/26 at 3:50 p.m., the

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A 116	Continued From page 4 Regional Director of Operations, Regional Director of Clinical Operations, and Executive Director confirmed Staff G failed to notify any administrative staff when the door alarm sounded and Tenant #2 was discovered missing during the overnight shift of 5/22/26 into 5/23/26, per policy guidance. 2. Record review on 6/01/26 revealed Tenant #1 had a diagnosis of dementia with agitation, depression, hypothyroidism, personal history of adult intimate partner abuse, restless leg syndrome, and anxiety. Tenant #1's GDS score on 5/05/26 was a 5, which indicated moderately severe cognitive decline. Tenant #1's service plan dated 3/02/25 revealed Tenant #1 was independent in dressing and toileting. Tenant #1 had an incident report dated 5/03/26 at 1:30 p.m. The report revealed Staff A entered the memory care unit and heard Tenant #1 calling out from her apartment. Staff A found Tenant #1's apartment door shut. Staff A opened the apartment door and observed Staff K sitting on the bed with Tenant #1 standing and facing him. Staff A reported Staff K's hand was down the front of Tenant #1's leggings. Staff A asked Staff K what he was doing, and Staff K reported he was changing Tenant #1's pants because she was incontinent. Staff A reported Tenant #1 immediately attempted to leave the apartment upon Staff A opening the door. A nurse's note dated 5/04/26 revealed the former Healthcare Coordinator documented she asked Tenant #1 if anything bad had happened to her lately, but Tenant #1 was unable to respond due to her advanced dementia. A second nurse's note dated 5/05/26 revealed the former Healthcare Coordinator completed a nurse review assessment of Tenant #1 but failed to mention anything about the recent allegations.	A 116		

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A 116	Continued From page 5 When interviewed on 6/02/26 at 11:42 a.m., Staff A stated he entered the memory care unit on 5/03/26 around 1:30 p.m. and heard Tenant #1 calling out. Staff A indicated Staff K was not observed in the common areas and Tenant #1's apartment door was shut. Staff A confirmed he opened the apartment door and observed Staff K sitting on Tenant #1's bed and Tenant #1 standing facing Staff K. Staff A reported Staff K had his hand down the front of Tenant #1's leggings. Staff A indicated Tenant #1 was making sounds like she was trying to make Staff K leave her alone or get away from her. Staff K told Staff A he was trying to take Tenant #1's pants off because she was incontinent. Staff A added Tenant #1 immediately ran to him when she saw him in her doorway, and then she attempted to leave the memory care unit shortly after. Staff A stated he immediately reported the incident to the former Healthcare Coordinator around 2:00 p.m. When interviewed on 6/04/26 at 11:00 a.m., Staff K confirmed that between 1:30 p.m. and 2:00 p.m. on 5/03/26, he attempted to change Tenant #1's pants because she had been incontinent. Staff K indicated he was unsuccessful due to Tenant #1 being combative, so he passed the duty on to the incoming next-shift staff. When interviewed on 6/02/26 at 8:45 a.m., the former Healthcare Coordinator confirmed she had just arrived at the Program around 2:00 p.m. on 5/03/26 to work a shift when Staff A reported what he saw between Staff K and Tenant #1. The former Healthcare Coordinator went back to the memory care unit right away to pass medications and saw Tenant #1. The former Healthcare Coordinator believed Tenant #1 looked fine. The former Healthcare Coordinator reported she had not assessed Tenant #1 that night after the	A 116		

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allegations to look for injuries. The former Healthcare Coordinator confirmed she had not called the Executive Director, nor had she called Tenant #1's family to notify them or ask if they wanted her evaluated at the emergency room. The former Healthcare Coordinator revealed she was Staff K's supervisor. She confirmed several tenants in the building did not want Staff K to perform cares with them or come into their apartments. The former Healthcare Coordinator believed Staff K was not reliable or trustworthy after getting to know him more.

When interviewed on 6/03/26 at 9:31 a.m., the Executive Director confirmed he was not made aware of the allegations regarding Staff K and Tenant #1 until the next day, 5/04/26. The Executive Director confirmed it was the Program's expectation for a nurse to assess a tenant as soon as allegations of abuse were known.

Record review of Program policies on 6/03/26 further revealed the Incident Report policy indicated the following: "Staff will notify the nurse or designee if a resident has fallen or any unusual event has occurred. The nurse is responsible to follow up with a review of reportable incidents and enter into the electronic health system as applicable."

When interviewed on 6/03/26 at 3:50 p.m., the Regional Director of Operations, Regional Director of Clinical Operations, and Executive Director confirmed the former Healthcare Coordinator failed to follow up on the allegations reported to her on 5/03/26. The former Healthcare Coordinator failed to assess Tenant #1 immediately and failed to notify the Executive Director of the allegations immediately per policy

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guidance.

3. Record review on 6/01/26 revealed Tenant #2 had a diagnosis of cardiomyopathy, hypertension, and a history of urinary tract infections. Tenant #2's last cognitive evaluation revealed a GDS score of 4 on 5/26/26, indicating moderate cognitive decline.

A nurse's note dated 5/26/26 revealed Tenant #2 was scheduled to return from a hospitalization on 5/27/26. The note revealed Tenant #2 was treated for a urinary tract infection while hospitalized. The hospital also discovered Tenant #2 had a back fracture that appeared old but caused Tenant #2 pain. Staff were to physically assist Tenant #2 upon return with transfers and mobility. The Program, in conjunction with the family, decided Tenant #2 would return to an apartment in the memory care unit of the building due to her changes in cognition and pain. A hospital report reviewed on 6/04/26 confirmed Tenant #2 returned to the Program from the hospital on 5/27/26. A second nurse's note made by the on-call staff, Staff L, dated 5/29/26, revealed Tenant #2 had been back from her hospitalization, but the family chose to take her to the emergency room on 5/29/26 due to uncontrolled back pain. Staff L documented they were not notified of Tenant #2's concerns until after she was taken to the hospital. Nurse's notes revealed no concerns reported by staff regarding Tenant #2 making complaints or showing signs of back pain between 5/27/26 and her hospitalization on 5/29/26. A review of Tenant #2's May 2026 medication administration record showed no pain medication was administered between 5/27/26 and 5/29/26.

When interviewed on 6/03/26 at 12:56 p.m., a

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family member of Tenant #2 confirmed the family chose to take Tenant #2 to the emergency room for assessment because she had a new cough in addition to continued back pain, and staff reported she had laid in bed all day and refused to eat. The family member confirmed Tenant #2 was admitted to the hospital with pneumonia.

When interviewed on 6/03/26 at 10:29 a.m., Staff J confirmed she worked the 2:00 p.m. to 10:00 p.m. shift on 5/28/26. Staff J indicated when she first arrived for her shift, the staff she replaced indicated Tenant #2 was fine and had only minimal back pain. Staff J reported later she assisted Tenant #2 with a transfer to the toilet and she took a long time to get out of her chair and transfer due to pain. Staff J added when she assisted Tenant #2 to bed, she had to obtain the assistance of a second staff member due to the difficulty of transferring her. Staff J reported Tenant #2 yelled out in pain when she was transferred to bed. Staff J asked Tenant #2 if she had any pain medication she could take, and she replied no.

When interviewed on 6/03/26 at 1:45 p.m., Staff D confirmed she worked part of the 2:00 p.m. to 10:00 p.m. shift on 5/29/26. Staff D confirmed at around supper, Tenant #2's family informed her Tenant #2 was bedbound and required changing as she was incontinent. Staff D added she was not able to complete the cares because she fell herself and had to go to the emergency room. Staff D noted another staff member took over for her in the memory care area.

When interviewed on 6/03/26 at 1:49 p.m., Staff I confirmed she took over the partial shift from Staff D on 5/29/26. Staff I reported she was told Tenant #2 was in bed all day and needed to be

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changed because she was incontinent. Staff I reported Tenant #2 was having increased back pain. Staff I added she had not heard Tenant #2 cough, but she had heard the family discuss the fact that she was coughing. Staff I had not called the on-call nurse to report Tenant #2 was in bed all day or had increased back pain. Staff I called the Assistant Director and on-call staff, Staff L, after Tenant #2 left for the emergency room between 7:00 p.m. and 8:00 p.m.

Record review of Tenant #2's hospitalization records on 7/02/26 revealed Tenant #2 was diagnosed with pneumonia of the left lower lobe, adult failure to thrive, immobility, uncontrolled pain, a recent urinary tract infection (diagnosed on 5/23/26), thrush, advanced dementia, and a fall with a resultant acute L1 fracture (the previous diagnosis of the fracture on 5/23/26 had indicated the fracture was old).

Record review of Program policies on 6/03/26 revealed a Resident Illness Policy. The policy indicated the following: "Staff shall notify the nurse or designee if a resident becomes ill or displays changes in behavior."

When interviewed on 6/03/26 at 3:50 p.m., the Regional Director of Operations, Regional Director of Clinical Operations, and Executive Director confirmed staff failed to notify the nurse or nurse on-call of Tenant #2's increased back pain and changes in behavior, such as staying in bed and refusing to eat on 5/29/26, per policy guidance.

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Tag #1	**481-67.2(2) — Program Policies and Procedures** This REQUIREMENT is not met as evidenced by: A 116 Based on interview and record review, the Program failed to follow policies related to incident reports and tenant illness	116	T2 evaluated by EMS/hospital 5/23/26. All current staff shall be educated on community Door identification and door alarm response by 10/23/26. Staff G received disciplinary action for not appropriately escalating/notifying on call nurse on 10/7/26 T1 was seen by nurse following reported incident on 5/3/26. Staff K was terminated on 5/6/26. The new HCC will be educated on comprehensive assessment expectation, emphasizing hands-on assessment of the resident and Incident notifications by 10/23/26.	New staff shall be educated regarding door identification and incident reporting-appropriate notifications and escalation within 30 days of hire or prior to working independently. Nurse/ Director/Designee shall audit staff knowledge on doors and door response four times per week for 4 weeks, monthly x 3 months or until compliance is reached. Nurse/Director/Designee shall audit incident report notifications as applicable weekly, monthly and as needed until compliance is reached.	**Implementation Date:** **Completion Date:** Ongoing **Responsible Party:** Directoror designee

Compliance Date: 10/25/26

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.