

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Adult Services Civil Penalty Citation**

<b>Date:</b>	November 30, 2017
<b>Program Name:</b>	Oak Park Place
<b>Address:</b>	1381 Pak Park Place Dubuque, IA 52002
<b>Type of Action:</b>	survey and investigations
<b>Date(s) of Action:</b>	October 30, 2017 to November 9, 2017

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	<p><b><u>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.</u></b></p> <p>Based on interview and record review the Program failed to provide services that that were adequate and appropriate regarding diabetic care for 1 of 6 tenants reviewed with diabetes (Tenant #11). Findings follow:</p> <p>Record review revealed Tenant #11 had diagnoses including dementia and diabetes mellitus type I. The tenant was staged at five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The service plan reflected staff administered medications.</p> <p>The October 2017 MAR reflected an order for Novolog insulin with a sliding scale. On 10-1-17 at 7:00 a.m. Tenant #11's blood sugar was 416; at 11:00 a.m. the blood sugar was 583; at 4:00 p.m. it was 406 and at 8:00 p.m. it was 559. Interdisciplinary Progress Notes dated 10-2-17 at 6:45 a.m. indicated Tenant #11's blood sugar was high the previous night and the nurse was notified by staff of the 559 reading taken at 8:00 p.m. That morning (10-2-17) Tenant #11's blood sugar registered as "High." Tenant #11 was unable to verbalize his/her name and was sent to the hospital. Family was notified. Further notes dated 10-2-17 at 11:30 a.m. revealed Tenant #11 was admitted to the hospital and was in the intensive care unit (ICU) for Ketoacidosis. An insulin drip was started.</p> <p>Tenant #11 returned to the Program on 10-4-17.</p> <p>There was no documentation of any notification of the nurse regarding Tenant #11's blood sugars on 10-1-17 regarding the 7:00 a.m., 11:00 a.m., 4:00 p.m. readings, all of which exceeded 400. There was no documentation regarding what, if any, actions were taken by the nurse notified of the 8:00 p.m. reading. Family was not notified of the elevated blood sugars until the next morning when Tenant #11 was sent to the hospital and was in ICU. There was no documentation of notification of the primary care provider regarding the elevated blood sugars. The MAR was updated on 10-4-17 to direct staff to call the nurse on call and family if blood sugars were less than 70 or greater than 400. The nurse on call would notify the primary physician. Tenant #11 did not receive services that were adequate and appropriate related to diabetic care.</p>	\$2000.00