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
	S0218	A. BUILDING: _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE	1381 OAK PARK PLACE DUBUQUE, IA 52002

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 39 Number of tenants with cognitive disorder: 22 Total Population of Program at time of on-site: 61 TOTAL census of Assisted Living Program: 61 A recertification visit was conducted to determine compliance with certification for a dedicated dementia-specific assisted living program. In addition to the recertification visit, investigation of Complaint #70617-C and Incident #70638-I were completed. The following regulatory insufficiencies were identified:	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003	See attached Plan of Correction DD 12/15/17	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow their policy related to dependent adult abuse for 1 of 11 tenants reviewed (Tenant #4). Findings follow: 1. Record review revealed Tenant #4 was admitted on 9-15-17 with a Global Deterioration Scale of 3 which indicated mild cognitive decline. An Incident Report dated 10-5-17 indicated Tenant #4 stated someone getting him/her ready in the morning inappropriately touched him/her. Tenant #4 was advised to talk to the Director of Health Care Services in the morning. Tenant #4 did not remember the name of the person who touched them but was adamant it happened. Family was notified on 10-5-17. The doctor was notified via fax. The Director of Health Care Services and the former nurse were notified on 10-5-17 at 11:30 a.m. The Director of Housing signed the Incident Report dated 10-23-17. An Investigation document indicated an initial investigation was completed on 10-5-17 and a supplemental investigation was completed by the Director of Housing on 10-30-17. The summary indicated Tenant #4 reported to a third shift staff that an employee came into the apartment and touched him/her inappropriately. An incident report was turned in and the Director of Health Care Services was notified. She left a message for family on 10-6-17. On 10-7-17 the Director of Health Care Services spoke with the family on the phone. The family member was not surprised and stated the tenant was disoriented. On 10-7-17 family came to the Program and the	A 003		

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A 003	Continued From page 2 Director of Health Care Services discussed the incident with them. The family believed that waking Tenant #4 up so often lead to the misinterpretation of the situation. Tenant #4 was new to the Program, was disoriented and staff woke him/her up every two hours to use the restroom. The Program's supplemental investigation completed on 10/31/17 revealed the tenant stated the touching was not sexual in nature. Someone had touched the tenant's feet to wake him/her up and he/she did not like that. Based on interviews with the tenant and staff, the Program's conclusion is that no inappropriate touching took place. 2. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed Tenant #4 reported to her that someone touched his/her foot and asked him/her to do inappropriate things. When asked what was inappropriate Tenant #4 said getting undressed on the lower half of his/her body. Tenant #4 seemed to think it was person of the opposite gender and did not think it was a staff. Tenant #4 thought it was someone from down the hall. It had been going on for two weeks per Tenant #4. Tenant #4's family was informed. The Program's conclusion was that the allegation was related to Tenant #4's adjustment, bladder infection and confusion. A physical evaluation was not completed. The Director of Health Care Services did not have any concerns regarding abuse related to the allegation. Interview with the Director of Housing on 11-6-17 at 2:21 p.m. revealed the former nurse knew about the allegation with Tenant #4. The Director	A 003		

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A 003	Continued From page 3 of Health Care Services called the family. The family came in and did not feel the tenant's claim of being touched inappropriately was true. The Director of Housing completed an investigation once he was made aware of the issue, including interviews with Tenant #4 and staff. He said the former nurse held onto the incident report regarding the allegation. The conclusion related to the allegation was that he agreed with the family stating the tenant struggled with urinary tract infections, did not want to be woken up every two hours and misinterpreted staff waking them up to use the restroom. 3. Further record review revealed the Program's policy regarding dependent adult abuse indicated the purpose included to ensure prompt and thorough investigation of alleged dependent adult incidents and timely report to appropriate agencies. The investigation process included to take immediate action to protect the dependent adult, collect detailed information about the dependent adult, the alleged perpetrator and other witnesses or people with information. The process was to start immediately by the person in charge. The investigative process included an assessment of the dependent adult. An allegation of possible abuse was reported to staff by Tenant #4 on 10-5-17. An incident report was completed and the former nurse and Director of Health Care Services were made aware. The Program completed an investigation of the allegation; however, the majority of the investigation was not completed until 10-30-17 and 10-31-17, weeks after the initial allegation by Tenant #4. An assessment of Tenant #4 for any possible injuries was not documented.	A 003		

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A 013	Continued From page 4	A 013		
A 013	481-67.3(2) Tenant Rights 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide services that that were adequate and appropriate including: housekeeping, which potentially affected all tenants (census of 61), bathing services for 9 of 11 tenants reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8 and #11) and diabetic care for 1 of 6 tenants reviewed with diabetes (Tenant #11). Findings follow: 1. 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. 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	A 013		

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A 013	Continued From page 5 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. Tenant #11 returned to the Program on 10-4-17. 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. 2. A community meeting with nine tenants revealed the housekeeping services provided needed to be more in depth and thorough. According to the tenants, there had previously been a dedicated housekeeper, however it was now up to direct care staff to fit in cleaning chores when able. They stated apartments were not always cleaned thoroughly. Review of the Program's Occupancy Agreement indicated	A 013		

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A 013	Continued From page 6 housekeeping services included daily bed making and up to one hour of housekeeping a week. Review of cleaning schedules for August 2017 revealed the following: - the schedule for AL apartments 100-110 and 200-230 indicated at least 10 apartments were not cleaned the week of 8/25/17 to 8/31/17 - the Memory Care Terrace schedules indicated there were over 10 times apartments were not documented as cleaned - the Memory Care Main schedules indicated there were over 10 times apartments were not documented as cleaned Review of the cleaning schedules for September 2017 revealed the following: - the schedule for AL Tenant apartments apartments 100-110 and 200-230 indicated six times apartments were not documented as cleaned - the Memory Care Main schedule indicated over 35 times apartments were not documented as cleaned, including two occupied apartments that appeared to have not been cleaned at all in September Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed when she first started there were complaints regarding lack of housekeeping services. She had not heard those concerns recently. Interview with the Director of Housing on 11-6-17 at 2:21 p.m. revealed he had not heard any complaints regarding housekeeping. He would make sure documentation of housekeeping would improve. 3. The community meeting revealed a concern with bathing services not being provided according to the service plan. According to the	A 013		

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A 013	Continued From page 7 Skin Evaluation policy and procedure, all tenants would have routine and as needed evaluations of skin with the goal of maintaining clean and intact skin. Staff were to evaluate tenants' skin and nails at admission and with each shower/bath and upon return from a hospital, skilled nursing facility stay or any overnight outing. Tenant #1's service plan indicated staff assisted Tenant #1 with bathing twice per week. Resident Services Record (RSR) for September 2017 revealed four times bathing was not documented as completed or as a refusal with no apparent follow up attempt. The RSR for October 2017 revealed four times bathing was not documented or as a refusal with no apparent follow up attempt. No Skin Evaluation sheets from 8-28-17 to 10-2-17 could be located. Tenant #2's service plan indicated staff assisted Tenant #2 with bathing. The RSR for August 2017 reflected three times bathing was not documented as completed. In September 2107 there were two times bathing was not documented as completed and the October 2107 RSR reflected three refusals were documented with no apparent follow up attempt. No Skin Evaluations sheets from 8-22-17 to 9-7-17 could be located. Tenant's #3's service plan indicated staff assisted Tenant #3 with bathing twice per week. The RSR for September 2017 indicated there were 10 times bathing was not documented as completed. No Skin Evaluation sheets from 8-20-17 to 9-6-17 could be located. Tenant #4's service plan indicated staff assisted Tenant #4 with bathing twice per week. The	A 013		

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A 013	Continued From page 8 September 2017 RSR documented bathing services from 9-18-17 to 9-23-17 (Tenant #4 was admitted on 9-15-17). Bathing was documented daily for six days and then not documented as completed after 9-23-17. Tenant #5's service plan indicated staff assisted Tenant #5 with bathing. The August 2017 RSR reflected two times bathing was not documented as completed. The September 2017 RSR reflected four times bathing was not documented as completed. Tenant #6's service plan indicated staff assisted Tenant #6 with bathing daily. The RSR for September and October 2017 did not reflect the daily bathing as indicated on the service plan. It was scheduled on the RSRs twice weekly. The September 2017 RSR reflected four times bathing was not documented as completed on the twice weekly schedule. Tenant #7's service plan indicated staff assisted Tenant #7 with bathing twice per week and as needed. The September 2017 RSR reflected one time bathing was not documented as completed. In October 2107 there were five noted refusals without any follow up attempt documented. Tenant #8's service plan indicated staff assisted Tenant #8 with bathing. The September 2017 RSR reflected three refusals without any follow up attempt documented. The October 2017 RSR reflected two refusals without any follow up attempt documented. Tenant #11's service plan indicated staff assisted Tenant #11 with bathing. The September 2017	A 013		

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A 013	Continued From page 9 RSR reflected three times bathing was not documented as completed. In October 2017 there was one time bathing was not documented as completed. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed there had been complaints regarding lack of bathing services when she started. She had not heard those concerns recently. Interview with the Director of Housing on 11-6-17 at 2:21 p.m. revealed there had been no concerns voiced to him regarding bathing services.	A 013		
A 058	481-67.9(4)a Staffing 481-67.9(231B,231C,231D) 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: a. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have the newly hired registered nurse document a review to ensure staff were	A 058		

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A 058	Continued From page 10 sufficiently trained and competent in all tasks within 60 days for 3 of 7 staff reviewed (Staff A, D and F). Findings follow: According to a staff list the Director of Health Care Services was hired on 8-29-17. The ALP Monitoring Entrance identified the Director of Health Care Services as the delegating nurse. Record review revealed Staff A was a personal care attendant (PCA) (universal worker) hired on 5-1-17. Staff A had a Skills Checklist Health Fair document completed on 10-12-17 and a Skills Checklist Summary Sheet signed by the Director of Health Care Services on 10-28-17. Despite the two training documents a review of all tasks by the current delegating nurse was not provided. A review of tasks that were not completed included: transferring from a bed to chair, ambulation, assistance with oral hygiene, partial bath, whirlpool bath, nail care, shaving and incontinent care. Record review revealed Staff D was a PCA (universal worker) hired on 8-14-17. Staff D had Skills Checklist Health Fair document completed on 10-12-17 and a Skills Checklist Summary Sheet signed by the Director of Health Care Services on 10-12-17. Despite the two training documents a review of all tasks by the current delegating nurse was not provided. A review of tasks that were not completed included: transferring from a bed to chair, ambulation, assistance with oral hygiene and incontinent care. Record review revealed Staff F was a PCA (universal worker) hired on 7-11-17. Staff F had a Skills Checklist Summary Sheet signed by the	A 058		

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A 058	Continued From page 11 Director of Health Care Services on 9-21-17. A review of tasks that were not completed included: hand hygiene, gloving, transferring from a bed to chair, ambulation, assistance with oral hygiene, partial bath, whirlpool bath, shower, nail care and vitals. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed all the staff reviewed assisted with activities of daily living.	A 058		
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide medications and treatments as prescribed by a physician for 6 of 11 tenants reviewed (Tenants #1, #4, #5, #6, #8 and #11). Findings follow: A community meeting with nine tenants was held. A tenant concern was voiced regarding a medication error that had occurred for a month. Another tenant concern voiced was when tenants returned from doctor appointments, sometimes paperwork provided to the Program was lost. A	A 147		

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A 147	Continued From page 12 review of medication error reports reveled between 8-12-17 and 10-21-17 there were over 15 documented medication errors. 1. Record review of Tenant #1's file revealed Interdisciplinary Progress Notes dated 9-28-17 that reflected Tenant #1 returned from the dental clinic with new orders from a tooth extraction. The orders, as noted on 9-28-17 at 1:00 p.m., stated Tenant #1 was not to rinse his/her mouth out for 24 hours after surgery and then rinse his/her mouth four to five times per day for 60 seconds. The notes stated the treatment book and care plan were updated. However, a review of the tenant's service plan did not reflect the dentist's instructions and the orders were not found on the September or October 2017 treatment records or medication administration records (MARs). Orders following the tooth extraction were not documented as completed for Tenant #1. 2. Tenant #4 had a an order dated 10-6-17 a for Lidocaine Patch 5%, apply topically one patch on for 12 hours, off for 12 hours. The October MAR on 10-19-17, 10-22-17 and 10-23-17 revealed staff initialed the completion of the application of the patch on at 7:00 a.m. On 10-19-17, 10-22-17 and 10-23-17 at 7:00 p.m. staff initialed, circled and indicated on the back of the MAR that the patch was not on Tenant #4 when they went to take it off. On the back of the MAR on 10-26-17 staff noted at 8:00 a.m. (when the application of a new patch was scheduled) that the patch was still on Tenant #4. The patch was not applied and removed per order for Tenant #4. 3. Tenant #5 had an order for ferrous sulfate tablet 325 milligram (mg) tablet, one tablet every	A 147		

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A 147	Continued From page 13 other day. According to the September MAR staff initialed the administration of the tablet from 9-2-17 to 9-8-17 each day and not every other day as ordered. Review of the tenant's September MAR revealed from 8-1-17 to 8-17-17 staff initialed the administration of Digoxin 0.125 mg. The medication was to be administered one time daily, however was to be held if the pulse was less than 60 or greater than 100. Tenant #5's pulse was not recorded until 8-18-17, despite the administration of the Digoxin. On 8-18-17 the following medications were not documented as administered: Amlodipine, aspirin, Atorvastatin, glimepiride, hydrochlorothiazide, lisinopril, Metformin, omeprazole, calcium/vitamin D and docusate sodium. 4. Tenant #6's Interdisciplinary Progress Notes dated 9-8-17 indicated Tenant #6 had a podiatry appointment to have the right big toenail and half of the left great toenail removed. Discharge instructions were provided. The orders indicated the tenant was to soak the foot in warm soapy water for 10 minutes, thoroughly dry the area, apply antibiotic ointment directly on procedure site and apply a Band-Aid once per day. The September 2017 treatment record indicated to complete foot soak in warm soapy water for 15 minutes to bilateral feet daily until the nurse deemed it was no longer necessary. The nurse was to be notified if there increased pain, swelling or redness. After soaking the foot staff were to apply a thin layer of antibiotic ointment and cover with a Band-Aid. If the Band-Aid would not stick they were to use roll gauze and paper tape. This treatment was discontinued on 9-29-17. From 9-9-17 to 9-29-17 (Tenant #6 went to the hospital on 9-18-17 and returned on	A 147		

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	S0218	A. BUILDING: _____ B. WING _____	C 11/09/2017

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A 147	Continued From page 14 9-20-17) staff documented the completion of the task seven times, despite the order for a daily treatment. Treatment orders were not followed for Tenant #6. 5. Tenant #8's file revealed a MD Notification Form signed on 10-1-17 by the Director of Health Care Services which indicated Tenant #8 had 4+ bilateral lower extremity tight edema and was non-compliant with elevation due to mental state. Tenant #8 complained of soreness in the left calf but the pain was not severe. The doctor questioned why he/she was being told of the issue eight days later and then inquired if Tenant #8 had any shortness of breath, redness or pain with walking. A basic metabolic panel, Lasix 20 mg every day for seven days and Potassium Chloride 10 milliequivalents every day for seven days were ordered. The order was noted on 10-9-17 but was not transcribed to the MAR. Interdisciplinary Notes dated 10-4-17 reflected Tenant #8 was admitted to the hospital with a blood clot in the left leg. 6. Record review revealed Tenant #11 had diagnoses including dementia and diabetes mellitus type I. A medication error report dated 10-27-17 indicated on 10-20-17 Tenant #11's blood sugar was 514 and staff gave 8 units of Novolog; however, the sliding scale indicated 12 units should have been given. Tenant #11's file revealed an Insulin Dose Sheet dated 10-19-17 that indicated 25 units of Lantus at breakfast was ordered and a sliding scale was provided for lunch, supper and bedtime. Ten units of Novolog were ordered if blood sugars at breakfast were between 351 and 400. Twelve units were ordered if blood sugars at lunch were over 450. Review of the October 2017 MAR revealed a	A 147		

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A 147	Continued From page 15 blood sugar of 374 at breakfast on 10-20-17. Staff documented the administration of 8 units of Novolog; despite the order for 10 units. The MAR revealed a blood sugar of 514 at 11:00 a.m. on 10-20-17. Staff documented the administration of 8 units of Novolog; despite the order for 12 units. According to a Insulin Dose Sheet dated 10-16-17, 22 units of Lantus were ordered at breakfast and a sliding scale for Novolog was provided for lunch, supper and bedtime. The orders were noted on 10-18-17. An Insulin Dose Sheet dated 10-19-17 indicated to stop prior insulin orders and to send blood sugars on 10-23-17. The orders were noted on 10-20-17. The orders indicated 25 units of Lantus at breakfast and a sliding scale for Novolog. An Insulin Dose Sheet dated 10-31-17 indicated to stop all prior insulin orders. The orders indicated 20 units of Lantus at breakfast and a sliding scale for Novolog. An Insulin Dose Sheet dated 11-1-17 indicated 20 units of Lantus at breakfast and a sliding scale for Novolog. The October 2017 MAR reflected two entries for Tenant #11's Lantus at breakfast. An injection of 22 units of Lantus with an original order date of 8-28-17 was on the October 2017 MAR. The 22 units was crossed out and 25 units was written with no date provided. Staff documented the administration of 22 units from 10-1-17 to 10-26-17 (except when Tenant #11 was out of the building). From 10-27-17 to 10-31-17 staff documented 25 units at breakfast. Another entry on the MAR reflected Lantus 22 units at breakfast with a 10-18-17 date. Staff initialed the administration of Lantus on 10-19-17 and 10-20-17. Staff documented the administration of Lantus 22 units at breakfast twice on the October 2017 MAR.	A 147		

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A 147	Continued From page 16 The October 2017 MAR reflected the tenant was to receive Lantus 25 units at bedtime with a start date of 10-20-17. However no order was ever received for this Lantus from the physician. Staff initialed the administration of 25 units of insulin at bedtime from 10-20-17 to 10-25-17 which was never ordered. Staff also initialed the administration of Lantus 22 units at 7:00 a.m. including from 10-20-17 to 10-25-17. Tenant #11 received 47 units of insulin between the units given at breakfast and bedtime for five days; despite the order for 25 units of Lantus at breakfast only. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed Tenant #11 received 22 units of Lantus at breakfast and 25 units at bedtime for five days in error as no physician order was ever obtained for the bedtime Lantus. The nurse who documented on the October MAR that an order for Lantus at bedtime had been given was no longer employed at the Program. Tenant #11 did not have an adverse reaction and the doctor was notified.	A 147		
A 040	481-69.23(1)c(1) Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and 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 sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or	A 040		

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A 040	Continued From page 17 aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 1 tenants reviewed who displayed aggressive and unmanageable verbal abuse was discharged as required (Tenants #7). Findings follow: Review of Tenant #7's file revealed a diagnosis of Lewy Body Dementia. The tenant was staged at a six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. Interdisciplinary Progress Notes dated 10-30-17 (late entry for 9-11-17) indicated Tenant #7 was very angry and yelled. Staff was able to redirect without difficulty. The related Incident Report dated 9-11-17 did not reflect Tenant #7 redirected without difficulty. Three direct care staff and the former nurse were involved with the incident before Tenant #7 was redirected. Notes dated 10-30-17 (late entry for 10-7-17) indicated Tenant #7 was very upset, swearing and acting violent towards staff. Tenant #7 swung and pushed a vacuum around and used it as a weapon. The Director of Housing was called and was able to assist with Tenant #7. Notes dated 10-9-17 indicated Tenant #7 was very upset and aggressive with staff. Tenant #7 kicked staff as they tried to prevent another tenant from being injured. The related Incident Report dated 10-9-17 indicated Tenant #7 said another tenant took his/her spouse and the other tenant was going to get killed. Staff redirected Tenant #7 without success. Tenant #7 kicked	A 040		

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A 040	Continued From page 18 staff as they blocked the other tenant from getting kicked. Notes dated 10-30-17 (late entry for 10-23-17) revealed Tenant #7 was yelling and swearing and using a broom as a weapon. Tenant #7 called staff names and swore at them as they were able to get the broom. Notes dated 10-24-17 indicated Tenant #7 tried to punch the doors (glass) and break them. Tenant #7 swung at staff and hit one staff twice in the hands. The tenant tried to hit the wall and tried to break a window. He/she threw a cup of water, chairs and pillows. Notes dated 11-3-17 (late entry for 10-30-17) indicated Tenant #7 was heard screaming and swearing about no one cleaning the floor. Tenant #7 became aggressive and started swearing. An Incident Report dated 10-26-17 indicated staff attempted to provided cares to Tenant #7. During various attempts and at different times of day Tenant #7 refused the cares and swore at staff. An Incident Report dated 10-28-17 indicated Tenant #7 was violent, yelled and swore. Tenant #7 stomped his/her feet and argued with other tenants. According to an Appointment Information document, a an order was received to increase Lorazepam 0.5 milligram (mg), one tablet twice daily and 0.5 mg one tablet every 12 hours for increased agitation. Seroquel was increased to 50 mg twice daily and the Seroquel 100 mg tablet at bedtime was continued. The order was noted on 10-25-17.	A 040		

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A 040	Continued From page 19 The service plan dated 9-6-17 indicated staff were to use cues and reapproach as Tenant #7 refused cares at times and could become physically aggressive. The service plan was updated on 11-3-17 to reflect staff were to redirect as needed when the tenant became aggressive and agitated. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed Tenant #7's medications were adjusted recently and there had not been any behaviors in a week or two. Tenant #7 had not harmed anyone. The Director of Health Care Service said Tenant #8's behavior was not appropriate and there was a plan to move Tenant #8. Tenant #8's family was not receptive to the move. Interview with the Director of Housing on 11-6-17 at 2:21 p.m. revealed staff were well trained and had the tools to redirect Tenant #7. There had been no injury to other tenants by Tenant #7. Staff called for assistance when needed. Further record review revealed the Occupancy Agreement indicated a tenant could not be retained if the tenant was a danger to self or others tenants or staff including but not limited to a tenant that was sexually or physically aggressive or had unmanageable verbal abuse. Tenant #7 exceeded the level of care regarding aggressive behaviors and unmanageable verbal abuse.	A 040		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall	A 071		

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A 071	Continued From page 20 be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurses' notes written by exception for 5 of 11 tenants reviewed (Tenants #1, #2, #4, #7 and #8). Findings follow: 1. Review of Tenant #1's file revealed Interdisciplinary Progress Notes dated 9-26-17 indicating Tenant #1 returned from the emergency room (ER) with new orders to repeat the basic metabolic panel on 9-29-17 and follow up with the primary care provider. The nurse failed to complete notes regarding when Tenant #1 left the Program for the ER and the reason for evaluation. Tenant #2's Interdisciplinary Progress Notes dated 8-2-17 (late entry) indicated Tenant #2 left the unit looking for their spouse. Tenant #2 was redirected back to the unit without difficulty. The entry was charted as a late entry for 8-2-17 and was charted after an entry dated 10-17-17. The nurse failed to document the incident when it occurred. Tenant #4's Interdisciplinary Progress Notes dated 9-22-17 indicated an order was obtained for a urinalysis and the results were obtained. An	A 071		

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A 071	Continued From page 21 order was received for Cipro 250 milligram every 12 hours for 7 days. The nurse failed to complete notes when the antibiotic was completed and to follow up regarding any further signs or symptoms of a urinary tract infection. Tenant #7's Interdisciplinary Progress Notes dated 10-30-17 (late entry for 9-11-17) indicated Tenant #7 was very angry and yelling. Staff was able to redirect without difficulty. Notes dated 10-30-17 (late entry for 10-23-17) indicated Tenant #7 started yelling and swearing and used a broom as a weapon. Tenant #7 called staff names and swore at them as they were able to get the broom. Notes dated 11-3-17 (late entry for 10-30-17) indicated Tenant #7 was heard screaming and swearing about no one cleaning the floor. Tenant #7 became aggressive and started swearing. The nurse failed to complete notes on Tenant #7 until several days after the incidents. Tenant #8's Interdisciplinary Progress Notes dated 10-30-17 (late entry for 10-22-17) indicated staff reported Tenant #8 touched/grabbed staff's buttock after staff patted him/her on the back. The nurse failed to complete notes until eight days after the incident. 2. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed she believed all Interdisciplinary Progress Notes were provided for the tenants reviewed.	A 071		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum:	A 089		

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A 089	Continued From page 22 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 develop service plans that reflected the identified needs for 9 of 11 tenants reviewed (Tenants #2, #3, #4, #5, #6, #7, #8, #9 and #11). Findings follow: 1. Review of Tenant #2's file revealed he/she was staged at six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. Tenant #2 had a diagnosis of dementia. According to a MD Notification Form dated 8-23-17, at approximately 10:30 a.m. Tenant #2 was with his/her spouse in the spouse's apartment outside of the secured memory care unit. Tenant #2 became angry with the spouse, left the spouse's apartment and went outside through a side door. The spouse was unable to keep up with Tenant #2 so they notified staff who went outside and found Tenant #2 in the front parking lot. Tenant #2 returned to the building with no problem. The service plan was updated on 8-23-17 and 8-24-17 to reflect Tenant #2 frequently visited the spouse. The spouse was instructed to push for the pendant for assistance or call on the phone immediately if Tenant #2 exited the spouse's apartment without him/her. Staff could assist the spouse with taking Tenant #2 to and from the spouse's apartment if requested. The service plan was updated on 9-19-17; however, did not	A 089		

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A 089	Continued From page 23 reflect the interventions related to incident on 8-23-17. Prior service plans reflected Tenant #2 entered others apartments and provided interventions related to this behavior. The 9-19-17 service plan did not reflect that Tenant #2 wandered into other tenant apartments. In addition, the October treatment record reflected an order to apply toe spacers/pads between toes for both feet daily. The service plan dated 9-19-17 did not reflect the treatment and issue with Tenant #2's toes/feet. 2. Tenant #3's Treatment Records for September and October 2017 reflected staff applied Nystatin to an abdominal rash/fold three times per day with a start date of 9-22-17. The service plan updated on 9-22-17 did not reflect the abdominal rash and treatment completed three times daily. 3. Tenant #4's service plan dated 10-13-17 reflected their bed was to padded and the tenant was to wear protective undergarments at bedtime. Staff were to check on him/her every two hours but were instructed not to wake the tenant or touch their feet. Staff was to only assist at night when the pendant was pushed. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. revealed staff assisted Tenant #4 with toileting one time per night. The service plan did not reflect the scheduled toileting assistance at night. 4. Tenant #5's service plan dated 10-11-17 did not reflect the frequency bathing services were to be provided. The Nurse Review dated 10-11-17 reflected bathing services were provided twice per week. September and October 2017 Treatment Records reflected an order for Aquaphor apply to bilateral arms/leg twice daily	A 089		

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A 089	Continued From page 24 as needed for dryness. The service plan dated 10-11-17 did not reflect the treatment or dryness to Tenant #5's arms/legs. 5. Tenant #6 had a diagnosis of traumatic brain injury and was staged at a four on the GDS which indicated moderate cognitive decline. The service plan dated 9-28-17 reflected Tenant #6 pushed on the doors to leave the unit, most frequently on third shift. Reminders included to redirect to his/her apartment or to the television room. Interdisciplinary Progress Notes dated 10-6-17 indicated Tenant #6 was exit seeking and punching in codes trying get out of the memory care unit. Staff redirected without success and Tenant #6 tried different codes until home care visited and gave him/her the code. Tenant #6 went into the general population unit and was redirected back. On 10-8-17 it was noted Tenant #6 knew the code and got out again. Maintenance was called to change the code. On 10-22-17 it was noted Tenant #6 left the unit, went with staff to get gum upstairs and was brought back to his/her apartment with no issues. A late entry for 10-25-17 (dated 10-30-17) indicated Tenant #6 punched in the code on the keypad and walked out of the unit. Staff followed him/her out and was able to redirect Tenant #6 back to the memory care unit. On 10-27-17 Tenant #6 pushed on the egress door longer than 15 seconds to open it. Staff was present and redirected Tenant #6. On 10-29-17 Tenant #6 set off the alarm. Staff was present and redirected Tenant #6. An Interdisciplinary Progress Notes dated 11-9-17 indicated Tenant #6's guardian informed the Director of Housing that Tenant #6 would likely be moving to another facility the week of 11-13-17. The service plan dated 9-28-17 did not reflect the extent of Tenant	A 089		

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A 089	Continued From page 25 #6's behavior as indicated in notes with pushing on the bar to release the door, punching in the code and interventions related to the behavior. 6. Tenant #7 had a diagnosis of Lewy Body Dementia and was staged at a six on the GDS which indicated severe cognitive decline. Interdisciplinary Progress Notes dated 10-30-17 (late entry for 9-11-17) indicated Tenant #7 was very angry and yelling. Staff was able to redirect without difficulty. Notes dated 10-30-17 (late entry for 10-7-17) indicated Tenant #7 was very upset, swearing and acting violent towards staff. Tenant #7 swung and pushed a vacuum around and used it as a weapon. The Director of Housing was called and he was able to assist with Tenant #7. Notes dated 10-9-17 indicated Tenant #7 was very upset and aggressive with staff. Tenant #7 kicked staff as they tried to prevent another tenant from being injured. Notes dated 10-30-17 (late entry for 10-23-17) indicated Tenant #7 started yelling and swearing and used a broom as a weapon. Tenant #7 called staff names and swore at them as they were able to get the broom. Notes dated 10-24-17 indicated Tenant #7 tried to punch the doors (glass) and break them. Tenant #7 swung at staff and hit one staff twice in the hands. Tenant #7 tried to hit the wall and tried to break a window. Tenant #7 threw a cup of water, threw chairs and pillows. Notes dated 11-3-17 (late entry for 10-30-17) indicated Tenant #7 was heard screaming and swearing about no one cleaning the floor. Tenant #7 became aggressive and started swearing. The service plan dated 9-6-17 indicated staff were to use cues and reapproach as necessary. Tenant #7 refused cares at times and could also be physically aggressive. The service plan was updated on 11-3-17 to reflect staff were to	A 089		

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
	S0218	A. BUILDING: _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE	1381 OAK PARK PLACE 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 089	Continued From page 26 redirect as needed when Tenant #7 became aggressive and agitated. The service plan did not reflect the extent of Tenant #7's behaviors and interventions related to the behavior. 7. Tenant #8's service plan dated 10-31-17 did not reflect the frequency bathing services were to be provided. The October Resident Services Record (RSR) reflected bathing was scheduled twice per week. 8. Tenant #9's service plan dated 10-4-17 did not reflect the frequency bathing services were to be provided. The October 2017 RSR reflected bathing was scheduled twice per week. 9. Tenant #11's service plan dated 9-27-17 did not reflect the frequency bathing services were to be provided. The September 2017 RSR reflected bathing was scheduled twice per week. In addition, Interdisciplinary Progress Notes dated 10-2-17 indicated Tenant #11's blood sugar was high the previous night and the nurse was notified by staff. That morning Tenant #11's blood sugar registered as "High." Tenant #11 was unable to verbalize his/her name and was sent to the hospital. Tenant #11 was admitted to the hospital and was in the intensive care unit for Ketoacidosis and an insulin drip was started. Tenant #11 returned to the Program on 10-4-17. Interdisciplinary Progress Notes dated 10-4-17 reflected Tenant #11 returned from the hospital from an episode of high blood sugar due to a urinary tract infection (UTI). Tenant #11 had an intravenous antibiotics in the hospital and did not return with antibiotics. Tenant #11 also returned with orders to evaluate and treat for physical therapy (PT). The service plan did not reflect Tenant #11 had a UTI or the need for a PT	A 089		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0218	A. BUILDING: _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE	1381 OAK PARK PLACE DUBUQUE, IA 52002

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A 089	Continued From page 27 evaluation. Interview with the Director of Health Care Services on 11-6-17 at 3:39 p.m. indicated she believed all service plans provided for the reviewed tenants were current.	A 089		
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 6 of 7 staff reviewed completed eight hours of dementia-specific education and training within 30 days of employment (Staff A, B, C, D, E and F). Findings follow: According to a certificate issued by the Department, the Program was a dedicated dementia-specific assisted living program. 1. Record review revealed Staff A was hired on 5-1-17. Post tests (Modules 1-4) regarding dementia training were found; however, the documents did not indicated the date completed or the number of hours completed. Staff A did	A 121		

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
	S0218	A. BUILDING: _____ B. WING _____	C 11/09/2017

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A 121	Continued From page 28 not have eight hours of dementia-specific education completed within 30 days of employment. Staff B was hired on 8-4-17 and did not have eight hours of dementia-specific education completed within 30 days of employment. Staff C was hired on 9-25-17 and did not have eight hours of dementia-specific education completed within 30 days of employment. Staff D was hired on 8-14-17. Staff D had eight hours of dementia-specific training completed on 10-17-17; however, it was not completed within 30 days of employment. Staff E was hired on 5-10-17 and did not have eight hours of dementia-specific education completed within 30 days of employment. Staff F was hired on 7-11-17 and did not have eight hours of dementia-specific education completed within 30 days of employment. 2. Interview with the Director of Housing on 11-6-17 at 2:21 p.m. revealed there had a been a lapse in dementia training in July/August during a transition between management staff. The plan going forward was to have monthly eight hour dementia-specific training for new staff hired and then an annual eight hour dementia-specific training.	A 121		

12/18/17

December 12, 2017

Department of Inspections and Appeals
Attn: Deb DIxon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Oak Park Place, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Complaint Investigation Report dated November 30, 2017. 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 insufficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Iowa law. Oak Park Place will not request a formal hearing.

Program Policies and Procedures
Dependent Adult Abuse

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Oak Park Place will follow policies and procedures related to any allegation of dependent adult abuse.
    - Oak Park Place will follow policies and procedures if Tenant #4 reports allegation of dependent adult abuse.

2. What measures will be taken to ensure the problem does not recur.
    - The Director of Housing and Director of Health Services will review Oak Park Place's Dependent Adult Abuse Policy. The policy will be signed and dated by the Director of Housing and Director of Health Services.
    - Staff will be re-educated on policies and procedures for Dependent Adult Abuse.
    - The Director of Housing and Director of Health Services will be educated on how to conduct a suspected dependent adult abuse investigation and on reporting criteria.

3. How the Program plans to monitor performance to ensure compliance.
    - The Housing Director and/or designee will review incident reports on a quarterly basis. This process will include evaluating if follow-up and/or reporting was completed if applicable.

12/15/17

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by December 30, 2017.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #11 will receive services that were adequate and appropriate related to diabetic care.
    - Tenant apartments will receive appropriate housekeeping services as identified in the occupancy agreement and service plan.
    - Tenants #1, 2, 3, 4, 5, 6, 7, 8, and 11 will receive bathing services as indicated on their service plan.

2. What measures will be taken to ensure the problem does not recur.
    - Staff will be re-educated on diabetic care including when to notify the nurse with hi/low blood sugars.
    - An apartment cleaning schedule will be monitored for completion.
    - A bathing schedule will be reviewed and updated.
    - Staff responsible for bathing will be retrained according to their service plan.

3. How the Program plans to monitor performance to ensure compliance.
    - The Director of Health Services and/or nurse designee will review diabetic care for applicable tenants when completing the 90 day nurse review.
    - The Director of Health Services and/or nurse designee will review services/interventions when completing the 90 day nurse review. For tenants not requiring a 90 day nurse review, the Director of Health Services and/or nurse designee will evaluate services at least annually. The purpose of this is to determine satisfaction of services provided.
    - At least annually during tenant council, tenant satisfaction with housekeeping and other services will be monitored.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by December 30, 2017.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - All staff will be sufficiently trained and competent in all tasks they are assigned.

2. What measures will be taken to ensure the problem does not recur.
    - The Skills Summary Checklist will be reviewed and updated to reflect tasks provided by staff.
    - The Health Services Director will be re-educated on training / delegation requirements to ensure staff is sufficiently trained. Training will include requirements related to documentation and ongoing monitoring.

3. How the Program plans to monitor performance to ensure compliance.

- The Housing Director and/or designee will audit staff training / delegation documentation at least annually to ensure compliance.

4. The date by which the regulatory insufficiency will be corrected.
   - Oak Park Place will be in compliance by December 30, 2017.

Medications

1. Elements detailing how the Program will correct each regulatory insufficiency.
   - Tenants #1, 4, 5, 6, 8, and 11 will have medications administered as ordered by the physician.

2. What measures will be taken to ensure the problem does not recur.
   - The Director of Health Services and nurse designee will be re-educated on protocol for processing physician orders.
   - The Director of Health Services and nurse designee will be re-educated on regulatory requirements for medication administration.
   - Staff responsible for administration of medications will receive additional training related to documentation and when to notify the nurse.

3. How the Program plans to monitor performance to ensure compliance.
   - The Director of Health Services and/or nurse designee will review medication orders at least every 90 days. This process will include ensuring physician orders are current, reviewing any potential changes, ill effects, and physician updates that may be required.

4. The date by which the regulatory insufficiency will be corrected.
   - Oak Park Place will be in compliance by December 30, 2017.

Criteria for Admission/Retention

1. Elements detailing how the Program will correct each regulatory insufficiency.
   - Please note we believe there may be a typo on the States Report. Page 20, paragraph 2 referred to Tenant #7 as Tenant #8.
   - Oak Park Place issued an involuntary transfer notice to Tenant #7.

2. What measures will be taken to ensure the problem does not recur.
   - The Director of Housing and Director of Health Services will be re-educated on occupancy criterion.

3. How the Program plans to monitor performance to ensure compliance.
   - The Director of Housing and Director of Health Services will monitor appropriateness of tenants ongoing.
   - The Director of Health Services and/or nurse designee will monitor appropriateness at least every 90 days when completing the 90 day nurse review. This process will include reviewing tenant identified needs to determine if tenant remains appropriate for assisted living level of care.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by December 30, 2017.

Tenant Documents

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Oak Park Place will meet regulatory compliance related to tenant documents for Tenants #1, 2, 4, 7, and 8.
    - The Director of Health Services and/or nurse designee will complete a nurse review, evaluation of tenant, and update the tenant's service plan for Tenants #1, 2, 4, 7, and 8.

2. What measures will be taken to ensure the problem does not recur.
    - The Director of Health Services and nurse designee will be re-educated on regulatory requirements for nurse review and evaluation of tenant.

3. How the Program plans to monitor performance to ensure compliance.
    - The Director of Housing, Director of Health Services, and/or designee will audit tenant charts at least two times per year to determine compliance with regulatory requirements for tenant documents.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by December 30, 2017.

Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The Director of Health Services will complete a service plan for Tenants #2,3, 4, 5, 6, 7,8,9, and 11. The service plan will reflect areas identified in the regulatory report, as applicable.

2. What measures will be taken to ensure the problem does not recur.
    - The Director of Health Services and nurse designee will be re-educated on regulatory requirements for service plan.

3. How the Program plans to monitor performance to ensure compliance.
    - The Director of Health Services, and/or designee will review services provided for accuracy at least every 90 days.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by December 30, 2017.

Dementia-Specific Education for Program Personnel

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Staff A, B, C, D, E, and F will receive 8 hours of dementia specific training.
    - All staff files will be reviewed to ensure staff has completed required dementia-specific training.

2. What measures will be taken to ensure the problem does not recur.
    - The Director of Housing and Director of Health Services will be re-educated on regulatory requirements for dementia specific training.
    - 8 hours of dementia specific training will be completed within 30 days of hire and annually.

3. How the Program plans to monitor performance to ensure compliance.
    - Staff training will be monitored at least annually to ensure compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by December 30, 2017.

Please contact me at 563-585-4900, 563-543-5119 (mobile) with any questions you have. Thank you.

Sincerely,

12-12-17

John Grothjan
Director of Housing