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 02/08/2017

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 000	481-67 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. General Population Program Number of tenants without cognitive disorder: 36 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 38 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 20 Total Population of Program at time of on-site: 22 TOTAL census of Assisted Living Program: 60 Investigation of Complaint #64965-C and Incident #64966-I was completed and the following regulatory insufficiency was identified:	A 000		
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. 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 3 tenants reviewed	A 089	See attached Plan of Correction 3/8/17	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 089	Continued From page 1 (Tenants #1 and #3). Findings follow: 1. Record review of Tenant #1's file revealed diagnoses of bipolar disorder, osteoporosis and compression fracture of multiple vertebrae. The service plan dated 1-6-17 indicated Tenant #1 was alert and oriented to person, place and time. The service plan dated 1-6-17 reflected staff was to assist Tenant #1 into the bathroom, on/off the toilet, and out of the bathroom using the walker and gait belt. Tenant #1 was independent with the remainder of toileting. When interviewed on 2-8-17 at at approximately 10:35 a.m. Tenant #1 said Staff A left them on the toilet one night and they had to call the Nurse for assistance. The tenant did not utilize their pendant to notify staff they were ready to leave the bathroom. When interviewed on 2-8-17 at 12:04 p.m. the Nurse confirmed an incident when Staff A had assisted the tenant onto the toilet and then left as it was the end of their shift. Staff A told the Nurse he had let oncoming staff know that Tenant #1 was on the toilet, however the oncoming staff stated they had not heard Staff A say this. Further interview with the Nurse on 2-8-17 at approximately 2:35 p.m. revealed the expectation for toileting assistance with Tenant #1 was that staff would ask the tenant each time if staff should remain in the area during toileting. There were no concerns regarding safety with staff leaving Tenant #1 on the toilet. Review of the service plan dated 1-6-17 indicated Tenant #1 was alert and oriented to person, place and time. The service plan reflected staff was to assist Tenant #1 into the bathroom, on/off the toilet, and out of the bathroom using the walker and gait belt. Tenant #1 was independent with the remainder of toileting. The service plan did	A 089		

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A 089	Continued From page 2 not provide direction that staff were to ask the tenant if they should remain in the area once Tenant #1 was assisted onto the toilet or how Tenant #1 was to notify staff to provide assistance off the toilet and out of the bathroom. 2. Record review of Tenant #3's file revealed diagnoses of attention deficit disorder, chronic static encephalopathy and pseudobulbar affect. Tenant #3 had a Global Deterioration Scale of three, which indicated mild cognitive decline. MD Notification Forms indicated the following: - On 1-9-17 Tenant #3 threw himself/herself on the floor when staff asked him/her to leave the common area due to having outbursts of yelling, hitting self, swearing and crying. Tenant #3 also started to bang his/her head against the wall and refused to get up. - On 1-17-17 Tenant #3 became upset and tipped over the chair he/she was sitting in, threw their walker across the hall, got into the elevator and threw self on the floor. Tenant #3 crawled to the banister and proceeded to scream, kick and hit self and bang their head against the wall. Tenant #3 was transported to the emergency room due to suicidal threats. - On 1-19-17 Tenant #3 was found on the floor in the Program's living room. Tenant #3 was scooting themselves across the floor and refused to get up. - Tenant #3 had numerous behaviors on the weekend including putting self on the floor on five times on 1-21-17 and once on 1-22-17. At those times Tenant #3 had yelled, threw things and shoved the walker at staff trying to assist.	A 089		

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A 089	Continued From page 3 - On 1-29-17 staff witnessed Tenant #3 put themselves on the floor because they could not talk to a preferred staff who was working in a different area of the building. Tenant #3 became verbally abusive and threw their walker at her. - On 2-6-17 at 5:55 p.m. Tenant #3 activated their pendant. When staff found Tenant #3 he/she was crawling out of a sitting room. Tenant #3 would not explain why he/she was on the floor and continued to crawl on the floor to their room. Tenant #3 refused assistance, threw the walker at staff, screamed and cried. At 6:10 p.m. Tenant #3 was witnessed putting self on the floor. At 9:00 p.m. Tenant #3 pushed their pendant. The tenant was found on the floor next to the bed and the walker with the pendant on it was across the room. Tenant #3 refused to get up and proceeded to destroy their room and broke his/her glasses. All three times Tenant #3 got themselves up without staff assistance. On 2-7-17 Tenant #3 threw the walker at one of the independent living tenants. Tenant #3 attended an adult day service (ADS) program and on 2-6-17 he/she threw things, including the walker and attempted to break a mirror while at the ADS. The service plan updated on 12-22-16 reflected Tenant #3 had outbursts of anger when told of concerns. Behaviors included banging their walker, rubbing their head and crying. When that occurred the service plan directed staff to talk calmly to Tenant #3 and to give time to calm down. If it continued staff were to walk away and give Tenant #3 time to calm down. Staff was to notify the Nurse if no improvement. The service plan did not reflect the tenant's behaviors of putting self on the floor, crawling on the floor, banging his/her head on the wall, throwing the	A 089		

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A 089	Continued From page 4 walker, making threats to harm self and damaging items in his/her apartment or interventions related to these behaviors.	A 089		

Oak Park place

A Progressive Senior Neighborhood

3/8/17

March 3, 2017

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

Dear Ms. Kellen:

On behalf of Oak Park Place, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Complaint/Incident Investigation Report dated February 8, 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.

Service Plan
The service plan shall be individualized and shall indicate, at a minimum, the tenant's identified needs and preferences for assistance.

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #1 and Tenant #3's service plan will be updated to include identified needs and preferences of service, including those areas addressed in the regulatory report, if applicable.

2. What measures will be taken to ensure the problem does not recur.
    - The RN will be re-educated on regulatory requirements related to service planning.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN Director or designee will monitor for compliance at least every 90 days when completing the 90 day nurse review. This process includes review of services provided to ensure interventions are identified on the service plan and to ensure current interventions remain appropriate.

1381 Oak Park Place, Dubuque, Iowa 52002
Local Phone: 563-585-4900 Fax: 563-582-6431
"An Alternative Continuum of Care Community

3/8/17

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by March 21, 2017.

Please contact me at 563-585-4900 with any questions you have. Thank you.

Sincerely,

Dara Fishnick
Director of Housing