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 11/07/2019

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

V 1/1/20

(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	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 disorder: 1 Number of tenants with cognitive disorder: 10 TOTAL Census of Assisted Living Program for People with Dementia: 11 The following regulatory insufficiencies were cited during the investigation of Complaint #85988-C and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program.	A 000		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a sufficient number of trained staff to fully meet tenants' identified needs potentially affecting all tenants (census of 11). Findings follow: 1. Review of the Program's Emergency Call	A 055	Plan of Correction is attached DD	

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

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A 055	Continued From page 1 System policy and procedure indicated each tenant would have an emergency call pendant to call staff for assistance. The system would be checked routinely and randomly to ensure it functioned properly. Tenants would be oriented to the pendant at admission and as needed. An acceptable staff response time to an activated call pendant was under 15 minutes. On a daily basis the Director of Housing or designee would complete a check of the pendant system on both wings. It would include a check of the pagers, monitors and staff response time. 2. Review of the weekly pendant report from 9-29-19 to 10-6-19 completed by the Program indicated there were 22 total calls during the time period with the longest response time being 26 minutes. Calls that were unacceptable were at 7.7% on first shift, 20% on second shift and 25% on third shift. The average daily unacceptable call rate was 13.6%. The weekly pendant report from 10-6-19 to 10-13-19 indicated there were 7 calls during the time period with the longest response time being an hour and 44 minutes. Calls that were unacceptable were at 50% on first shift, 100% on second shift and 0.0% on third shift. The average daily unacceptable call rate was 28.6%. The weekly pendant report from 10-13-19 to 10-20-19 indicated there were 21 calls during the period with the longest response time being 40 minutes. Calls that were unacceptable were at 16.7% on first shift, 22.2% on second shift and 0.0% on third shift. The average daily unacceptable call rate was14.3%. The weekly pendant report from 10-20-19 to	A 055		

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A 055	Continued From page 2 10-27-19 indicated there were 6 calls during the period with the longest response time being 31 minutes. Calls that were unacceptable were: 0.0% on first and second shifts and 50% on third shift. The average daily unacceptable call rate was16.7%. 3. When interviewed on 11-7-19 at 1:39 p.m. the Director of Housing revealed the corporate expectation was to answer the pendants in 15 minutes or less.	A 055		
A 059	481-67.9(4)b 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: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure nurse delegations were completed within 30 days of beginning employment for 1 of 3 staff reviewed employed greater than 30 days (Staff B). Findings follow: Review of Staff B's file on 11-5-19 revealed a hire date of 5-25-19. Staff B's training on tasks	A 059		

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A 059	Continued From page 3 including activities of daily living was completed on 7-2-19, which was greater than 30 days from employment. When interviewed on 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed he was not aware of the 30 day timeframe for delegations.	A 059		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a criminal history and abuse record background check prior to employment for 1 of 6 staff reviewed (Staff A). Findings follow: Review of Staff A's record on 11-5-19 of Staff A's revealed a hire date of 7-11-19. A criminal background check and abuse registries background check was completed on 10-15-19 and revealed no results were found. A background check completed prior to	A 118		

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A 118	Continued From page 4 employment was not found. When interviewed on 11-7-19 at 1:39 p.m. the Director of Housing confirmed no other background checks were found for Staff A.	A 118		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure evaluations were completed within 30 days of taking occupancy and as needed with significant change for 1 of 1 tenants reviewed who was admitted in 2019 (Tenant #1). Findings follow: 1. Record review on 11-6-19 of Tenant #1's file	A 037		

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A 037	Continued From page 5 revealed a Progress Note dated 6-24-19 indicating Tenant #1 was admitted for respite care. A Health and Functional Assessment dated 7-18-19 reflected it was a 30 day nurse review and Tenant #1's spouse had decided to admit her to the memory care unit. Evaluations were completed on 7-18-19 and 7-19-19 when Tenant #1 became a permanent tenant and was no longer a respite tenant at the Program. Cognitive, health and functional evaluations were not completed within 30 day of Tenant #1's occupancy as a non-respite admission. A Progress Note dated 10-25-19 indicated Tenant #1 was sent to the emergency room (ER) in the evening of 10-24-19 due to shortness of breath and abdominal pain. Tenant #1 was diagnosed with a urinary tract infection (UTI) and started on Keflex 500 milligrams four times per day for 10 days. Evaluations were not completed as needed with significant change when Tenant #1 went to the ER, was diagnosed with a UTI and received antibiotic therapy. 2. When interviewed on 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed all evaluation documents requested for Tenant #1 were provided.	A 037		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care	A 085		

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A 085	Continued From page 6 or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of taking occupancy and as needed with significant change. This pertained 1 of 1 tenant reviewed that was admitted in 2019 (Tenant #1). Findings follow: 1. Record review on 11-6-19 of Tenant #1's file revealed Progress Notes dated 6-24-19 indicated Tenant #1 was admitted for respite care. A Health and Functional Assessment dated 7-18-19 reflected it was a 30 day nurse review and Tenant #1's spouse had decided Tenant #1 would be staying long term in the memory care unit. Tenant #1 would be moving out of the respite room to another room on the unit. A service plan was developed dated 7-22-19 when Tenant #1 became a permanent tenant and was no longer a respite tenant at the Program. A service plan was not updated within 30 days of Tenant #1's occupancy as a non-respite admission. Continued record review of Progress Notes dated 10-25-19 indicated Tenant #1 was sent to the emergency room in the evening of 10-24-19 due to shortness of breath and abdominal pain.	A 085		

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A 085	Continued From page 7 Tenant #1 was diagnosed with a urinary tract infection (UTI) and was started on Keflex 500 milligrams four times per day for 10 days. The service plan was updated on 10-25-19; however, it was not updated as a significant change and was not based on evaluations or signed. 2. When interviewed on 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed all service plan documents requested were provided for Tenant #1.	A 085		
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 observation, interview and record review the Program failed to ensure service plans reflected identified needs for 3 of 3 his pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. On 11-6-19 review of Tenant #1's file revealed an MD Notification Form dated 9-4-19 indicating Tenant #1 had been pocketing her medications in her mouth and spitting them out. An order was requested to crush the medications and put them in pudding, ice cream or yogurt. An order was received for the above request dated 9-4-19.	A 089		

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A 089	Continued From page 8 When observed on 11-5-19 at 4:00 p.m. medications were administered by Staff A. Medications were crushed and placed in yogurt and administered to Tenant #1. When interviewed on 11-6-19 at 6:27 a.m. Staff C revealed Tenant #1 was toileted on third shift approximately every two hours. When interviewed on 11-6-19 at 6:34 a.m. Staff D revealed Tenant #1 was toileted on third shift every two hours. Tenant #1's service plan last reviewed 7/9/19 was not updated to reflect the issue of pocketing medications and the order for crushed medications. It also did not reflect the toileting assistance on third shift. 2. On 11-6-19 review of Tenant #2's health and functional assessment dated 9/12/19 revealed the tenant required the use of a walker and stand by assistance to ambulate. When interviewed on 11-6-19 at 6:27 a.m. Staff C revealed Tenant #2 was toileted on third shift approximately every two hours. When interviewed on 11-6-19 at 6:34 a.m. Staff D revealed Tenant #2 was toileted on third shift every two hours. Tenant #2's service last reviewed 6-17-19 was not updated to include her mobility needs or toileting assistance on third shift. 3. When interviewed on 11-6-19 at 6:27 a.m. Staff C revealed Tenant #3 was toileted on third shift approximately every two hours.	A 089		

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A 089	Continued From page 9 When interviewed on 11-6-19 at 6:34 a.m. Staff D revealed Tenant #3 was toileted on third shift every two hours. On 11-6-19 review of Tenant #3's file revealed the service plan last reviewed 2-27-19 did not include the frequency of toileting assistance to be provided. 4. When interviewed on 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed all service plan documents requested for the tenants listed above were provided.	A 089		

1/7/20

December 18, 2019

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 Memory Care in Dubuque, Iowa, I respectfully submit our Plan of Correction for your approval. Our response is specific to the certification visit report for November 7, 2019, onsite visit. 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.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant emergency call pendants will be answered by staff within 15 minutes.
    - The RN will review delegated training specific to Staff B. Delegations will be reviewed and completed as appropriate.

2. What measures will be taken to ensure the problem does not recur.
    - Staffing plan will be reviewed to ensure Oak Park Place has sufficient staffing to meet tenant identified needs.
    - Staff will be re-educated on the tenant emergency call system and response expectation.
    - All nursing staff will receive appropriate training/delegation within 30 days of hire by the RN.
    - The RN will ensure that staff have appropriate training/delegation prior to completing tasks.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director and/or Designee will audit emergency response times at least two times per year to ensure staff is responding within 15 minutes or less.
    - The RN or Designee will review staff files at least two times per year to ensure staff has appropriate training/delegations on file.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

1/3/20

Record Checks

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Criminal History and Abuse Record Background check was completed for Staff A.

2. What measures will be taken to ensure the problem does not recur.
    - Criminal History and Abuse Record Background checks will be completed prior to employment.

3. How the Program plans to monitor performance to ensure compliance.
    - Staff responsible for maintaining employee files will be re-educated on requirement for completion of required background checks prior to employment.
    - The Administrator will be re-educated on requirement of background checks being completed prior to employment.
    - A new hire checklist will be developed to ensure background checks are completed prior to employment.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #1 will have an evaluation completed by the RN.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated on regulatory requirements for evaluation of tenants, including identifying potential changes in condition.
    - The RN and/or Designee will be re-educated on regulatory requirements when a tenant transitions from respite care to new admission to the program.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will review tenant files at least every 90 days to ensure evaluations are completed as required by regulation and that evaluations are reflective of the tenant.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Service Plan

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenants #1, #2, and #3 will have service plans updated by the RN. Service plan will identify tenant needs and preferences for assistance as well as any outside service providers.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated on regulatory requirements for service plan development.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will review tenant files at least every 90 days to ensure service plans identify tenant needs, preferences for assistance and outside service providers.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Please contact me at 563-543-5119 with any questions you have. Thank you.

Sincerely,

Cheryl Scheele
Executive Director