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 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE MEMORY CARE	**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	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: 16 Total census: 17 Complaints #108006-C, #108716-C and #109298-C were investigated and the following regulatory insufficiencies were cited:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) 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 and procedures regarding the completion of incident reports for 2 of 4 tenants reviewed (Tenants #2 and #3), abuse/staff misconduct for 1 of 1 tenants reviewed with facial bruising of unknown etiology (Tenant #2) and drug/alcohol use which potentially affected al tenants (census of 17). Findings follow: 1. Review of Tenant #2's file on 3/1/23 revealed an incident report dated 11/26/22 reflecting staff notification to the Nurse of Tenant #2's bruised right eye. Staff had not notified the Nurse when it was first noted on Friday. The Nurse started an investigation immediately. The incident report indicated Tenant #2 had a hematoma on her right eye. Facial bruising was first noted on 11/25/22 at	A 150	The Plan of Correction is attached.	

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

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6:20 a.m. The incident report was dated 11/26/22 at 11:19 a.m. The incident report was not completed when staff noted the bruising on Tenant #2's eye on 11/25/22 at 6:20 a.m. It was not completed until more than 24 hours and multiple shifts from when Tenant #2's injury was first noticed.

The Notes section on the incident report indicated Staff C called the Nurse to give her an update on Tenant #2's condition. The Nurse was unaware of the occurrence for Tenant #2. The Nurse collected statements from staff who worked on 11/24/22 and 11/25/22. She called the Director of Housing who was unaware of the bruising as well. The Director of Housing called (former) Staff G, who worked on third shift on 11/24/22 for her statement. This interview or statement was not documented. The Notes indicated the Nurse interviewed five staff related to the occurrence. Two staff noticed the bruising on 11/25/22 on first shift at 6:00 a.m. One staff indicated there was dark purple bruising on Tenant #2's right eye but nothing was reported at shift change between third shift and first shift. It was noted staff did not complete rounds together. One staff interview indicated (former) Staff G was working the overnight shift on 11/24/22 and staff reported she was frustrated as there were four tenants, including Tenant #2, who were wandering. Another staff reported she came in to help (former) Staff G as there were tenants up and wandering on third shift and (former) Staff G was the only staff. The staff indicated Tenant #2 was up and down all night and needed assistance from Staff G to go back to bed. The staff did not see Tenant #2 when she came in to help. The Notes indicated the investigation of the potential abuse was not founded and all staff were allowed to work their shifts. Staff was educated on the

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timely notification of the Nurse. On 11/28/22 it was noted Tenant #2 was noted to be rubbing her eye, which caused a small bruise to her outer eye.

When interviewed on 3/2/23 at 11:50 a.m. Staff C said she was working in memory care and got Tenant #2 up and noticed a bruise on her eye. She described it a kind of a black eye. She called either the Nurse or the Assistant Director of Housing.

When interviewed on 3/14/23 at 11:00 a.m. (former) Staff G said she did not recall an incident with facial bruising for Tenant #2 and she was not interviewed related to it by leadership staff. She said she did not provide a statement.

When interviewed on 3/2/23 at 12:21 p.m. the Nurse said day shift staff found Tenant #2 with a bruise on her eye. The staff wanted to make sure the Nurse was aware. She had not previously been made aware of the bruising prior to that call. She called corporate staff and was told to call the Director of Housing and to get staff statements. There were no reports of falls and no reports of anyone being aggressive. The Nurse said Tenant #2 moved around on her own and was on a blood thinner. She completed the interviews over the phone and then put them in the incident report notes. The investigation was unfounded.

When interviewed on 3/8/23 at 2:45 p.m. and 3:47 p.m. the Director of Housing said the Nurse called her and asked if anything had been reported to her regarding bruising for Tenant #2. She interviewed (former) Staff G by phone but did not document her interview. Staff G told her she did not see Tenant #2 up and about on her shift and did not notice any bruising on her. The

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Director of Housing said there were no reports of anyone rough or aggressive and no witnesses and it was determined there was no abuse. She said Tenant #2 was on a blood thinner and wandered. In addition, family told them the tenant was known to rub her eyes. She said there was an error in communication (related to the delay) and estimated it was between 12 to 18 hours from when staff first noticed Tenant #2's bruising until it was reported to the Nurse.

The Program's Emergency Accidents and Incidents policy and procedure indicated all accidents or incidents would be reported to the Director of Housing and others in a timely manner. An incident report would be completed when an occurrence or event "leads to unintentional consequences and an unfortunate happening" including to a tenant.

The Program's policy and procedure for Abuse/Caregiver Misconduct indicated to report the situation immediately. Witness statements from all staff working must be completed. The Director of Housing would complete an investigation including interviewing staff, tenant and family, an assessment of the tenant and a determination and conclusion.

Requested schedules for the time of the allegation were not available, a written investigation except the Notes section on the incident report was not documented or provided and (former) Staff G's statement was not documented. There was also no documented interviews with family or Tenant #2. The policies were not followed as an incident report was not completely timely related to Tenant #2's bruising of unknown etiology and the abuse policy was not followed as it was not reported immediately, a full

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investigation was not completed and documented and it did not include witness statements from all staff working and interviews the tenant and family.

2. Review of Tenant #3's file on 3/2/23 and 3/8/23 revealed a Progress Note dated 1/16/23 indicating she fell over the weekend and hit her head. A neurological assessment was unremarkable. Tenant #3 was alert and oriented per her baseline.

When interviewed on 3/1/23 at 1:47 p.m. Staff A said Tenant #3 had bruising on her wrist about two months prior. She said the bruising was not there on first shift but was when she came back the next day. The bruise was brown/purple in color. She did not know if any incident report was completed. She said it should have been reported to either the Nurse or Assistant Director of Housing.

Continued record review revealed incident reports was not completed related to Tenant #3's fall with hitting her head or when bruising was noted to Tenant #3's wrist.

3. When interviewed on 3/1/23 at 1:42 p.m. Staff A reported Staff H was fired for having an edible (marijuana) gummy on her shift. She said it happened four months ago.

On 3/1/23 at 2:13 p.m. Staff B said Staff I would go out and smoke "blunts" in his car and return to the building smelling like pot. She saw it happen several times on third shift. She said she did not report it as was legal where Staff I lived.

When interviewed on 3/14/23 at 11:00 a.m. (former) Staff G said about the half the building

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A 150	Continued From page 5 worked under the influence on second and third shifts. Staff I and Staff J would go outside for a break and return smelling like marijuana and acting more quiet and reserved. It occurred in October 2022. She said it happened a couple of times and she reported it to the Assistant Director of Housing, the Director of Housing and the Nurse. When interviewed on 3/2/23 at 1:59 p.m. the Assistant Director of Housing said Staff H was suspected to be under the influence in October/November 2022. Staff C, the shift supervisor, went to the building to check on her. She did not appear to be under the influence and was acting fine. The Assistant Director of Housing and Director of Housing interviewed Staff H by phone and she admitted to being under the influence as she had taken half of an edible. Staff H was a medication passer. They checked the medication cart and right and the pendant response times and there were no issues. Staff H was subsequently terminated. There were no other staff reported to be under the influence at work. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing stated she was not involved with the situation with Staff H and was not made aware until after she was terminated. She was informed there was speculation Staff H was under the influence while at work. Staff C came in and Staff H denied she was under the influence. Staff H finished her shift. The following Monday Staff H sent the Assistant Director of Housing a message and told her she had taken an edible. Staff H was terminated over the phone by the Director of Housing and Assistant Director of Housing. She was not aware of any other staff who had been at work under the influence.	A 150		

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A 150	Continued From page 6 The Program's Substance Abuse policy and procedure prohibited the "use, possession, sale, solicitation, or transfer of illegally obtained drugs or alcohol while on the premises" of the Program. That included staff that reported to work under the influence "illegal drugs, alcohol, or non-prescribed drugs." 4. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed she would expect staff to complete an incident report the same day, there were no other incident reports for the tenants listed above, and all investigation materials were provided related to Tenant #2's occurrence of bruising and the Program had a zero tolerance policy related to staff drug and alcohol use.	A 150		
A 160	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 care, treatment and services that were adequate and appropriate for 1 of 4 tenants reviewed (Tenant #4). Findings follow: 1. When interviewed on 3/1/23 at 1:42 p.m. Staff	A 160		

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A said some staff on second shift in memory care needed more dementia training. She said Staff D talked very loud to the tenants, did not approach the tenants correctly and was kind of forceful (verbally). It had occurred when trying to redirect tenants to their apartments from the dining room table. On second shift Tenant #4 had her pendant taken away by staff because she pressed her button. It happened about four months ago and she told staff to give it back to her.

When interviewed on 3/1/23 at 2:13 p.m. Staff B said there were staff who were rude or verbally abusive to tenants, such as when tenants did not sit still and refused to eat. Staff occasionally yelled at tenants to sit down when they were getting into everything. She said Tenant #4 pressed her pendant for no reason and the pendant was taken away at least once per week. It was not done on a particular shift and the length of time varied.

When interviewed on 3/2/23 at 11:50 a.m. Staff C said Tenant #4 used her pendant.

When interviewed on 3/1/23 at 3:34 p.m. Staff D said Tenant #4 used her pendant.

When interviewed on 3/8/23 Staff E said Tenant #4 used her pendant.

When interviewed on 3/8/23 at 12:21 p.m. Staff F said Tenant #4 used her pendant a lot.

2. Review of Tenant #4's file on 3/2/23 revealed Tenant she was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #4's service plan indicated she was at risk for falls due to impulsivity and for staff to remind her to use her

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A 160	Continued From page 8 pendant for assistance. Continued record review revealed Tenant #4 had falls including 10/28/22, 11/29/22, 12/8/22, 1/9/23, 1/10/23, 1/12/23, 1/20/23, 1/31/23, 2/10/23, 2/16/23 and 3/1/23. A request for a history of Tenant #4's pendant calls was requested however not available past the prior shift. 3. Review of the Program's Emergency Call System policy indicated all tenants would have an emergency call pendant to call staff for assistance. Tenants would be encouraged by staff to have their pendants with them at all times. 4. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing said she was not aware of any tenants having their pendants taken away. She said Tenant #4 used her pendant and it was always around her neck. She had not received any reports related to staff being rude or verbally abusive towards tenants.	A 160		
A 104	481-69.4(7) Application Content 481-69.4(231C) Nonaccredited program-application content. An application for certification or recertification of a nonaccredited program shall include the following: 69.4(7) The policy and procedure for accidents and emergency response, including provisions related to head injuries. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a policy and procedure that addressed the provisions related to head	A 104		

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A 104	Continued From page 9	A 104		

injuries. This pertained to 3 of 3 current tenants reviewed who had fallen and hit their heads (Tenants, #1, #3 and #4). Findings follow:

1. Review of Tenant #1's file on 3/1/23 and 3/2/23 revealed an incident report dated 11/30/22 indicating the tenant was found on the floor face down and had a "lump" on her the right forehead. Tenant #1's family was notified and declined to send her out for evaluation. Tenant #1 was placed in bed with ice on her head. Scheduled Tylenol was given.

2. Review of Tenant #3's file on 3/2/23 and 3/8/23 revealed Progress Notes dated 1/16/23 indicating the tenant fell over the weekend and hit her head. Neurological assessment was unremarkable. Tenant #3 was alert and oriented per her baseline.

3. Review of Tenant #4's file on 3/2/23 revealed an incident report dated 1/20/23 indicating the tenant's pad alarm went off. Staff staff responded to find Tenant #4 sitting on the floor next to her bed. She had an abrasion on the top of her scalp and discoloration noted to her hip.

4. When asked for the head injury policy, a Change in Condition Notification Protocol document was provided. The document outlined circumstances in which staff should notify the nurse, which incluided falls with head injuries. The document did not provide the policy and procedure related to the provisions of falls with head injury, with the exception of when to notify the nurse.

5. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed there was no additional policies and procedures regarding

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A 104	Continued From page 10 provisions related to falls with head injuries.	A 104		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall 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, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change for 2 of 4 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Review of Tenant #1's file on 3/1/23 and 3/2/23 revealed an annual evaluation was dated 8/24/22 and 90 day nurse review reviews were dated 11/23/22 and 1/18/23. Progress Notes revealed the following: - On 12/12/22 a communication to the physician note requested to consult hospice if Tenant #1's family was agreeable due to her not eating and the progressive decline. - On 12/12/22 a discussion was had with Tenant #1's family regarding hospice services.	A 145		

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A 145	Continued From page 11 - On 12/21/22 Tenant #1's diet order was changed from pureed diet to mechanical soft. Cognitive, health and functional evaluations could not be located with significant change related to admission to hospice, not eating, progressive decline and diet order change. 2. Review of Tenant #2's file on 3/1/23 revealed a 30 day evaluation was dated 10/10/22 and 90 day nurse reviews were completed on 11/23/22 and 2/20/23. Progress Notes indicated the following: - On 11/15/22 Tenant #2 had two stage 1 pressure ulcers on her buttocks. The nurse applied barrier cream and spray. - On 11/23/22 Tenant #2's primary care provider was updated on Tenant #2's pressure sores and agreed with the current plan of care. - On 1/23/23 it was verified with pharmacy that all medication listed on 1/23/23 could be crushed. - On 2/20/23 Tenant #2 had 2+ bilateral edema and a new order was obtained for compression stockings. - On 3/1/23 Tenant #2's family had concerns related to depression and a psych consult was received. Cognitive, health and functional evaluations could not be located with significant changes related to pressure sores and treatment, crushed medications, order for compression hose and psych consult due to depression. 3. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed all evaluations for the tenants listed above were provided.	A 145		
A 290	481-69.25(1)i Tenant Documents	A 290		

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A 290	Continued From page 12 69.25(1) Documentation for each tenant shall 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 document nurse's notes by exception for 4 of 4 current tenants (Tenants #1, #2, #3 and #4) and 2 of 2 discharged tenants (Tenants C1 and C2) reviewed. Findings follow: 1. Review of Tenant #1's file on 3/1/23 and 3/2/23 revealed Progress Notes indicated the following: - On 11/29/22 Tenant #1 was vomiting, had facial flushing, had a fever and was weak. - On 11/29/22 Tenant #1 was transported to the emergency department via ambulance - On 11/29/22 Tenant #1 tested positive for influenza A and her lactate level was 3.8 and would be redrawn. The note indicated it was not determined if Tenant #1 would be admitted and it would be based on the redraw. - On 11/30/23 Tenant #1 fell that morning, landed on her face and had a lump forming. Tenant #1's family declined to have her sent out for evaluation. Continued record review revealed a nurse's note was not completed related to Tenant #1's return from the hospital and if any new orders were received related to positive influenza A status.	A 290		

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OAK PARK PLACE MEMORY CARE	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 290	Continued From page 13 2. Review of Tenant #2's file on 3/1/23 revealed Progress Notes indicated the following: - On 11/15/22 Tenant #2 had two stage 1 pressure ulcers on her buttocks. The nurse applied barrier cream and spray. - On 11/23/22 Tenant #2's primary care provider (PCP) was updated on Tenant #2's pressure sores and was "on board with our current plan of care." There were no additional entries related to the pressure ulcers and condition of the wounds. 3. Review of Tenant #3's file on 3/2/23 and 3/8/23 revealed Progress Notes indicated the following: - On 11/17/22 Tenant #3 complained of rectal pain. It was noted Tenant #3 had hemorrhoids. An order was received for an anusol application. The next entry in Progress Notes was dated 1/13/23 and it was not related to Tenant #3's rectal pain and hemorrhoids or treatment. 4. Review of Tenant #4's file on 3/2/23 revealed Progress Notes indicated the following: - On 10/18/22 Tenant #4 had signs and symptoms of a respiratory infection and tested positive for COVID-19 the day prior. Tenant #4's PCP was contacted. - On 10/20/22 Tenant #4 continued to have congestion related to COVID-19. An order was received for Mucinex, scheduled for three days and then as needed for 10 days. Continued record review revealed nurse's notes were not completed for Tenant #4 related to her respiratory symptoms and COVID-19 status post 10/20/22.	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 290	Continued From page 14 5. Review of Tenant C1's file on 3/13/23 revealed Tenant C1 was discharged on 11/29/22. Review of Progress Notes indicated the last entry in notes was dated 10/31/22. A nurse's note was not completed related to the reason or date for Tenant C1's transfer. 6. Review of Tenant C2's file on 3/13/23 revealed Tenant C2 was discharged on 12/17/22. Review of Progress Notes indicated the last entry in notes was dated 12/5/22. The entry indicated Tenant C2's spouse was interested in a trial period for the tenant at the non-memory care area of the building. A nurse's note was not completed related to the reason or date of Tenant C2's transfer. 7. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed all nurse's notes were provided for the tenants listed above	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 350	Continued From page 15	A 350		

based on evaluations and updated when neeeds changed for 2 of 4 tenants reviewed (Tenants #1 and #2). Findings follow:

1. Review of Tenant #1's file on 3/1/23 and 3/2/23 revealed the service plan was last reviewed on 2/21/23. The service plan reflected revision dates in December 2022, January and February 2023. Evaluations were not completed when the service plan was updated to include hospice services, repositioning, two person assistance with transfers, notification of skin changes to the nurse, increase in toileting assistance, assistance with wheelchair mobility and non-slip grip in Tenant #1's wheelchair. The service plan was not based on evaluations as evaluations were not completed when the noted changes above were added to the service plan.

Continued record review revealed Tenant #1 received hospice services. The service plan did not reflect the services provided by hospice and frequency of those services.

2. Reivew of Tenant #2's file on 3/1/23 revealed the service plan was last reviewed on 3/1/23. The service plan reflected revision dates including January, February and March 2023. Evaluations were not completed when the service plan was updated with crushed medications due to an aspiration incident, compression hose assistance, encouragement to elevate her legs and encouragement to sleep in bed related to her lower leg edema. The service plan was not based on evaluations as evaluations were not completed when the noted changes above were added to the service plan.

Progress Notes indicated the following:
- On 11/15/22 it was noted Tenant #2 had two

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A 350	Continued From page 16 stage 1 pressure ulcers on her buttocks. The nurse applied barrier cream and spray. - On 11/23/22 Tenant #2's primary care provider was updated on the pressure sores and was "on board with our current plan of care." The tenant's service plan was not updated and did not reflect Tenant #2's pressures sores and treatment. 3. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed all evaluations and service plans for the tenants listed above were provided.	A 350		
A 385	481-69.26(3)d Service Plans 69.26(3) When a tenant needs personal care 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. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated and signed and dated within 30 days of occupancy for 2 of 2 tenants reviewed admitted in 2022 (Tenants #2 and #4). Findings follow: 1. Review of Tenant #2's file on 3/1/23 revealed an occupancy date of 9/14/22. Tenant #2 did not have a signed service plan since her admission to	A 385		

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A 385	Continued From page 17 the Program, including within 30 days after taking occupancy. 2. Review of Tenant #4's file on 3/2/23 revealed an occupancy date of 6/3/22. Tenant #4 did not have a signed service plan since her admission to the Program, including within 30 days after taking occupancy. 3. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed all service plans for the tenants listed above were provided.	A 385		
A 390	481-69.26(3)e Service Plans 69.26(3) When a tenant needs personal care 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. e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated and signed at least annually for 2 of 2 tenants in occupancy for over one year (Tenants #1 and #3). Findings follow: 1. Review of Tenant #1's file on 3/1/23 and 3/2/23 revealed an occupancy date of 6/24/19. Tenant #1's most recent signed service plan was dated 6/19/2020. Tenant #1 did not have a service plan updated and signed at least annually.	A 390		

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A 390	Continued From page 18 2. Review of Tenant #3's file on 3/2/23 and 3/8/23 revealed an occupancy date of 4/13/21. Tenant #3's most recent signed service plan was dated 4/13/21. Tenant #3 did not have a service plan updated and signed at least annually. 3. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed all service plans for the tenants listed above were provided.	A 390		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to completed a nurse review as needed for 1 of 1 tenants with facial bruising of unknown etiology (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 3/1/23 revealed an incident report dated 11/26/22 reflected staff notified the Nurse of Tenant #2's bruised right eye. Staff had not notified the Nurse when it was first noted on Friday. The Nurse started an	A 430		

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A 430	Continued From page 19	A 430		

investigation immediately. The incident report indicated Tenant #2 had a hematoma on her face. A head to toe assessment was completed with no other findings. The incident report indicated facial bruising was first noted on 11/25/22 at 6:20 a.m. and Tenant #2 had no complaints of pain. The incident report form indicated staff interviews were started.

Continued review of Tenant #2's file revealed a nurse review was not completed related to Tenant #2's injury/bruising of unknown etiology. The file did not indicated the color of the bruising, the size of the area, the specific location of the bruising on or around her eye. The incident report noted a head to toe assessment was completed; however, an assessment was not documented. A nurse review was also not completed when Tenant #2's facial bruising resolved.

Nurse reviews were not completed as needed for Tenant #2 related to her injury/bruising of unknown etiology, which required the initiated of an internal investigation.

2. When interviewed on 3/8/23 at 3:47 p.m. the Director of Housing confirmed all nurse reviews for the tenant listed above were provided.

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. This response is specific to the report for the onsite visit between 02/28/2023 and 03/14/2023. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusion set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Program Policies and Procedures

1. Elements detailing how the program will correct each regulatory insufficiency.

   -Policies and Procedures regarding the completion of incident reports will be followed as established by the program.

   -The program's Substance Abuse Policy and procedure will be followed as established by the program.

2. Measures taken to ensure the problem does not recur.

   -All current Direct Care Staff will be provided with specific education on the current policy and procedure for completion of incident reports.

   -All new staff upon hire will be provided with education on the policy and procedure to complete incident reports for Oak Park Place.

   -Staff member that reported to work under the influence was terminated on November 1, 2022.

   - All current Direct Care Staff will be provided with specific education on the current Substance Abuse Policy and Procedure.

   - All new staff upon hire will be provided with education on the current Substance Abuse Policy and Procedure for Oak Park Place.

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

-The Director of Housing, Director of Health Services and/or Designee will monitor completion of the Policy and Procedure for Incident Reports education for all new employees. Staff who do not complete training within 30 days of hire will be removed from the schedule until completion of training.

-All current staff will receive training to review the current Oak Park Place Policy and Procedure for completion of incident reports. If not completed, staff will be removed from the schedule.

-Health Services Director, Director of Housing and/or Designee will monitor incidents and evaluate for any non-compliance every 90 days.

- The Director of Housing, Director of Health Services and/or Designee will monitor completion of the Substance Abuse Policy and Procedure education for all new employees. Staff who do not complete training within 30 days of hire will be removed from the schedule until completion of training.

- All current staff will receive training to review the current Oak Park Place Substance Abuse Policy and Procedure. If not completed, staff will be removed from the schedule.

4. The date by which the regulatory insufficiency will be corrected.

-The Regulatory Insufficiency will be corrected on or before May 27, 2023.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency.

-The Program will provide care, treatment and services that are adequate and appropriate to each tenant.

2. Measures taken to ensure the problem does not recur.

-All Direct Care Staff will receive training regarding Dementia Care including techniques on approach and redirection. Staff will be trained in how to communicate concerns to nurse and/or administration related to behavioral changes or difficulty with redirection.

-All Direct Care Staff will receive training regarding Emergency Call System Policy.

-Tenants will be assessed to determine their ability to understand and appropriately utilize the emergency response pendant. The service plan will identify safety checks for those tenants who are unable to functionally or cognitively use a pendant.

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

-The Director of Housing, Director of Health Services and/or Designee will monitor completion of the Dementia Care education for all new employees. Staff who do not complete training within 30 days of hire and annually will be removed from the schedule until completion of training.

-All current staff will review the Dependent Adult Abuse policy specific to definition of abuse.

- All current staff will receive additional training related to dementia and tenant redirection/approaches. training to review the current Oak Park Place for Dementia Care education. If not completed, staff will be removed from the schedule.

4. The date by which the regulatory insufficiency will be corrected.
-The Regulatory Insufficiency will be corrected on or before May 27, 2023.

Application Content

1. Elements detailing how the Program will correct each regulatory insufficiency.

-The program will have a Policy and Procedure for accidents and emergency response, including provisions related to head injuries.

2. Measures taken to ensure the problem does not recur.

-The Program has instituted a Fall with Head Injury Policy and Procedure.

-All Direct Care Staff will receive training related to Fall with Head Injury Policy and Procedure.

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

- All current staff will receive training to review the current Oak Park Place Policy and Procedure for Fall with Head Injury. If not completed, staff will be removed from the schedule.

- The Director of Housing, Director of Health Services and/or Designee will monitor completion of the Fall with Head Injury Policy and Procedure education for all new employees. Staff who do not complete training within 30 days of hire will be removed from the schedule until completion of training.

- The Director of Housing, Director of Health Services and/or Designee will review incidents for compliance with the Fall with Head Injury Policy and Procedure quarterly.

4. The date by which the regulatory insufficiency will be corrected.

-The regulatory insufficiency will be corrected on or before May 27, 2023.

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency.

-The program will complete a health, functional, and cognitive evaluation as required by regulation.

2. Measures taken to ensure the problem does not recur.

-An audit was completed on 4/20/2022 to ensure all assessments are current.

- The Director of Housing, Director of Health Services and/or Designee will monitor for compliance every 90 days.

-The licensed nurse will be re-educated on regulatory requirement for Evaluation of Tenant.

-Incoming Director of Health Services will be educated on procedure for documentation and evaluation of tenant.

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

- Director of Health Services and/or Designee will review the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy and medication; and nurses' notes written by exception at least every 90 days to ensure compliance.

4. The date by which the regulatory insufficiency will be corrected.

-The regulatory insufficiency will be corrected on or before May 27, 2023.

Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency.

   -The Program will ensure service plans are based on evaluations and updated as needed or with a significant change in condition.

   -The Program will ensure service plans will identify tenant needs and preferences as required by regulation.

2. Measures taken to ensure the problem does not recur.

   -All resident assessments and services plans are being reviewed and updated by the Director of Health Services Designee. Updated service plans to be signed by tenants/healthcare designee, Director of Health Services Designee and then filed in the tenant's chart.

   -Tenant #1 and Tenant #2 service plans were reviewed and updated to ensure they identified tenant needs and preferences as required by regulation.

   -The Director of Health Services will be educated on regulatory requirements for service plan completion.

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

   -Director of Health Services and/or Designee will review resident service plans every 90 days.

4. The date by which the regulatory insufficiency will be corrected.

   -The regulatory insufficiency will be corrected on or before July 1, 2023.

Service Plans

1. Elements detailing how the program will correct each regulatory insufficiency.

   -The Program will ensure service plans are updated and signed and dated within 30 days of occupancy.

2. Measures taken to ensure the problem does not recur.

-Education provided to admitting assessment nurse, sales team regarding Service Plan Regulations.

-All tenant service plans are being reviewed, updated and signed per Service Plan Regulations.

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

-Director of Health Services and/ or Designee and/ or Director of Housing and/ or Designee to routinely audit Service Plan compliance.

-Incoming Director of Health Services to be educated on Service Plan Regulations.

4. The date by which the regulatory insufficiency will be corrected.

-The regulatory insufficiency will be corrected on or before May 27, 2023.

Nurse Reviews

1. Elements detalling how the Program will correct each regulatory insufficiency.

-The Program will ensure nurse reviews are completed as required by regulation.

2. Measures taken to ensure the problem doesn't recur.

-The medical information sheet, documentation of health professionals' orders, such as those for treatment, therapy and medication are being reviewed to identify a potential change in condition every 90 days.

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

-The Director of Health Services and/or Designee will audit tenant charts at least every 90 days for compliance.

4. The date by which the regulatory insufficiency will be corrected.

-The regulatory insufficiency will be corrected on or before May 27, 2023.

✓ 5/22/23

If you have any questions regarding this plan of correction, please feel free to contact me at 563-585-4900.

Sincerely,

Candice Heinkel

Director of Housing