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 05/19/2023

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: 0 Number of tenants with cognitive disorder: 19 Total census: 19 The following regulatory insufficiency was cited during the investigation into Complaint #112178-C.	A 000		
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 appropriate services to 1 of 2 current tenants reviewed (Tenant #1). Findings follow: Record review on 4/12/23 of Medication Administration Records (MARs) for January revealed Tenant #1 was administered the medication Ropinirole HCL, 1 mg. daily, for the treatment of restless leg syndrome through 1/30/23. The MAR reflected Tenant #1 was started on the medication Risperdal, 2mg. daily, for the treatment of mild cognitive impairment on	A 160	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

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 05/19/2023

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 160	Continued From page 1	A 160		

1/30/23. The Ropinirole was discontinued that same day. These changes were made by the former Director of Clinical Services (DOCS).

Review of a packing slip from the pharmacy dated 1/27/23 revealed the program received 14 tablets of Ropinirole HCL, 2mg. for Tenant #1. The pharmacy did not send any Risperdal as the MAR was not changed until after the pharmacy delivery on 1/27/23.

The February MAR included Risperdal but not Ropinirole (as it had been discontinued on the MAR on 1/30/23). However, staff documented the entire month of administering Risperdal to the tenant when in actuality she was being given the Ropinirole sent by the pharmacy on 1/27/23.

Tenant #1 met with her primary care provider (PCP) on 2/27/23. The program provided Tenant #1 with a list of medications to take with her which reflected she took Risperdal but was no longer taking Ropinirole. Tenant #1 returned to the program with an appointment information sheet which did not reflect a change in her oral medication.

On 3/1/23, the DOCS documented she received notice the pharmacy medication pack was different from how it was ordered on the computer. The medication pack contained Risperdal and no Ropinirole. The DOCS contacted the PCP to get an updated medication list. The medication list from the PCP, dated 3/1/23, included Risperdal 2mg. two tablets daily, but no Ropinirole.

The tenant was administered Risperdal at 4:00 pm on 3/1/23 and 7:00 am on 3/2/23. She received no Ropinirole as it

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 05/19/2023

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 160	Continued From page 2	A 160		

was not on the medication list sent to the pharmacy by the PCPs office following the visit on 2/27/23..

A progress note from 3/2/23 documented staff were concerned Tenant #1 was increasingly weak and confused. The DOCS assessed Tenant #1 and a neurological check was completed without concern, however Tenant C1's speech was slurred. Tenant #1 was transported to the hospital for an evaluation of a potential stroke.

Tenant #1 was admitted to the hospital on 3/2/23 for a possible acute stroke with new left facial droop and slurred speech. The physician noted he spoke with the hospital pharmacist who discovered the patient had been on Ropinirole for a couple of years but on 3/1/23 there was a medication error and Tenant #1 was started on Risperdal 2mg. twice daily. The pharmacist called the program and the PCP's office and learned the Risperdal was not a medication the PCP intended Tenant #1 to take.

Tenant #1 was discharged from the hospital on 3/6/23 back to the program. The discharge summary noted Tenant #1 had increased dysarthria (difficulty speaking due to weak muscles), slurred speech and generalized weakness. A work-up revealed no physical evidence on the CT, MRI or MRA of a stroke. However the remote neurology services did feel Tenant #1 may have had a very small stroke. It was also documented Tenant #1 had a medication mishap with receiving Risperdal in place of Ropinirole. Risperdal was discontinued upon admission to the hospital. Tenant #1 was diagnosed with acute metabolic encephalopathy/delirium which was improving. The condition was multifactorial. Tenant #1 was

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 05/19/2023

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 160	Continued From page 3	A 160		

previously diagnosed with dementia and was outside of her normal surroundings.

On 4/12/23 at 4:30 PM, the office manager at the PCP's office reported Tenant #1 was seen by her PCP on 12/7/23 and the visit notes indicated Tenant #1 was taking Ropinirole 1mg daily. There was no mention of medication changes. There was no mention of an office visit on 1/30/23 or of a call from the program asking for a medication change. On 2/27/23 the tenant was seen by her PCP for a four month check-up. The clinic nursing staff updated the PCP's medication list from the list supplied by the program. At that time, Ropinirole was not on the medication list but Risperdal was. The PCP's office added Risperdal to her current medications from the list provided by the ALP.

On 4/13/23 at 8:55 AM, the Director of Housing and the Regional Nurse confirmed the DOCS incorrectly updated the MAR on 1/30/23. The DOCS manually entered the information into the MAR discontinuing the Ropinirole and adding the Risperdal. This led to Tenant #1 providing an inaccurate medication list to her PCP on 2/27/23.

On 5/19/23 at 10:45 AM an interview and follow-up email with the Clinical Associate Professor at the University of Iowa's College of Pharmacy revealed the drug Ropinirole should be tapered off, generally over at least one week, to prevent dopamine antagonist syndrome. The symptoms can be orthostatic hypotention, confusion and anxiety. Ropinirole increases the levels of dopamine. He believed the tenant's symptoms seemed to be neurological. Risperdal blocks dopamine. The two drugs would be contradicted. She would have a precipiced withdrawal. Abruptly stopping Ropinirole and

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 05/19/2023

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 160	Continued From page 4 starting Risperdal would be pretty traumatic on her system. From reviewing the medical records, it didn't appear as if she had a stroke. There was no focal weaknesses in her limbs and the CT did not show any acute bleed.	A 160		

July 20, 2023

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 in Dubuque, I'm submitting our Plan of Correction for your approval. Our response is specific to the onsite visit which ended on May 19, 2023. 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 provision of state law.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency, including at the system level.
    - Oak Park Place will verify medication orders with Tenant #1's physician.
    - Tenant #1 will receive medications as ordered by the physician.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or nurse designee will review processes for receiving and processing physician orders.
    - The RN and/or nurse designee will be educated on processes for noting orders, entering orders on the MAR, storage of medications, and disposal of discontinued medications.
    - Staff will be re-educated on medication administration, specifically the five rights of medication administration.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN or Designee will monitor for compliance at least every 90 days. The monitoring process will include reviewing medications to ensure orders are current and accurate.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be completed by August 20, 2023

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

Sincerely,

Candice Heinkel
Director

ok