PRINTED: 04/02/2024
FORM APPROVED

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
	80218	A. BUILDING: _____ B. WING _____	C 01/17/2024

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 impairment: 0 Number of tenants with cognitive impairment: 16 Total census: 16 The following regulatory insufficiencies were cited during the investigation of Complaint #115152-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
A 220	481-67.4(4) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(4) When a tenant elopes from a program. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to notify the Department within 24 hours, or the next business day, by the most expeditious means available regarding the elopement of 1 of 5 tenants reviewed (Tenant #3) Findings include: 1. On 1/16/24, a review of Tenant #3's record revealed an admission date of 11/7/23. Tenant	A 220	481-67.4(4) Program Notification to The Department- The Director or the Director's Designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(4) When a tenant elopes from a program. 1. Elements detailing how the Program will correct each regulatory insufficiency. • Tenant #3 continues to reside in the program. • Director of Housing, Regional Nurse, and Health Services Director or Designee will review all incident reports to determine if incident requires notification to the Department. 2. Measures taken to ensure the problem does not reoccur. • Director of Housing, Regional Nurse, and Health Services Director will be provided with specific education on Iowa Code 481-67.4(4) related to Notification to the Department when a tenant elopes from the program. 3. How the program plans to monitor performance to ensure compliance. • The program will monitor compliance by auditing incident reports at least 2 times per year for compliance related to Notification to the Department. 4. Date by which the Regulatory Insufficiency will be corrected. • The Regulatory Insufficiency will be corrected on or before May 1, 2024	

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A 220	Continued From page 1 #3's global deterioration scale (GDS) was a score of 5 on 11/24/23. Tenant #3's record revealed an initial evaluation completed on 11/2/23 indicating a history of elopement at her previous assisted living apartment. Tenant #3's 30 day service plan dated 11/24/23 contained information regarding her history of elopement. 2. On 1/16/24, the past 3 months of Program incident reports were reviewed. No incident reports on elopement were observed. 3. On 1/16/24 at 12:58 pm, Staff A stated Tenant #3 had an elopement several weeks ago during a first shift. Tenant #3 stated she learned of the elopement when she arrived for work on second shift. Staff A could not recall the specific day the incident occurred. Staff A stated it was reported Tenant #3 had left the memory care unit for approximately 5 minutes without staff knowledge. 4. On 1/17/24 at 10:40 am, the Director of Housing confirmed an elopement had occurred on 12/26/23 by Tenant #3. The Director of Housing provided the hand written incident report as well as statements taken by staff on 12/26/23. The Director of Housing indicated Tenant #3 had walked through the open door of the memory care unit when a visiting family member opened the door using the keypad to enter the unit and allowed Tenant #3 to exit. Tenant #3 immediately entered the elevator outside of the unit and went to the second floor of the assisted living program. Tenant #3 exited the elevator and walked across the hall to the assisted living's bingo room. An assisted living staff member observed Tenant #3 standing outside of the bingo room and returned her to the memory care. Tenant #3 had no injuries. The Director of Housing indicated video footage of the hallways showed Tenant #3 left the	A 220		

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A 220	Continued From page 2 memory care at 12:52 pm. Tenant #3 was returned to the memory care unit at 12:56 pm. 5. On 1/17/24 at 11:27 am, Staff B stated she was working first shift when Tenant #3 left the memory care. Staff B stated she was in the restroom when Tenant #3 left the unit. On 1/17/24 at 11:33 am, Staff H stated she was working first shift when Tenant #3 left the memory care. Staff H observed the family visit Tenant #3. When the family left the unit, Staff H redirected Tenant #3 away from the memory care door that led into the assisted living program side of the building. Staff H took Tenant #3 to the living room area of the memory care to sit. Staff H then went to perform a different task. Staff H stated approximately 5 minutes later, Staff D returned Tenant #3 to the memory care unit. On 1/17/24 at 2:40 pm, Staff D stated she observed Tenant #3 standing in front of the bingo room on the second floor of the assisted living program. Staff D stated she redirected Tenant #3 back down to the memory care unit with no concerns. Tenant #3 had no injuries. 8. On 1/17/24 at 11:17 am, the Director of Housing stated the Program had not reported the elopement to the Department.	A 220		
A 435	481-67.19(5) Record Checks 67.19(5) Employment prohibition. A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services. This REQUIREMENT is not met as evidenced by:	A 435		

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A 435	Continued From page 3 Based on interviews and record review, the Program failed to obtain an evaluation from the department of health and human services prior to hire for 1 of 1 staff reviewed with a history of child abuse (Staff F). Findings include: On 1/17/24, a review of Staff F's personnel file revealed a hire date of 2/6/23. Staff F's personnel file revealed an initial SING (single contact repository) report which was run on 1/30/23. The child abuse results stated to "Initiate record check evaluation process by completing form 470-2310 and submitting it to DHS." This evaluation process was not completed. On 11/13/23, the Program ran SING reports for all hired staff as a precautionary measure. The child abuse results for Staff F stated the same message to complete the evaluation form and send it to DHS. Again the Program did not complete the evaluation process. On 1/17/23 at 3:30 pm, the Director of Housing confirmed these findings.	A 435	481-67.19 (5) Record Checks- Employment prohibition. A person who has committed a crime or has a record of Founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services. 1. Elements detailing how the Program will correct each regulatory insufficiency. • Staff member F was immediately placed on a Leave of Absence and subsequently terminated from employment with Oak Park Place. 2. Measures taken to ensure the problem does not reoccur. • All new hires will be appropriately screened prior to hire for Criminal check, Child Abuse, and Dependent Adult Abuse. • Director of Housing will be provided with specific education related to SING completion and requirements related to initiating the record check evaluation process and submission of the completed form 470-2310 to DHS for approval. 3. How the program plans to monitor performance to ensure compliance. • The Director of Housing and or designee will monitor staff files for compliance at least two times per year. 4. The date by which the regulatory insufficiency will be corrected. • Regulatory Insufficiency will be corrected on or before May 1, 2024	
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs)	A 330		

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OAK PARK PLACE MEMORY CARE	1361 OAK PARK PLACE DUBUQUE, IA 52002

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A 330	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the program staff failed to complete the documentation of all routine personal care tasks that were identified in the service plan for 1 of 2 former tenants reviewed (Tenant C1) Findings include: On 1/16/24, a review of Tenant C1's record revealed an admission date of 8/3/22. Tenant C1 was discharged to a higher level of care on 11/14/23. Tenant C1's service plan dated 9/14/23 on page 11, revealed staff directives to complete routine safety checks. Tenant C1's service plan also indicated on page 2, Tenant C1 required staff to check for incontinence during rounding, or routine checks. On 1/17/24 at 11:15 am, the Regional Nurse confirmed routine safety checks were every 2 hours. On 1/16/24, a review of service plan task sheets for the last 2 months the tenant resided in the Program were completed. - October 2023 task sheets for routine safety checks in conjunction with incontence checks revealed 372 total checks staff were to be completed. Documentation reviewed showed 64 of the 372 checks had no documentation in October of 2023. - November 2023 task sheets for routine safety checks in conjunction with incontence checks revealed 183 total checks staff were to be completed prior to her discharge on 11/14/23. Documentation reviewed showed 6 of the 183 checks had no documentation in November of	A 330	81-69.25(1)q Tenant Documents- Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) 1. Elements detailing how the Program will correct each regulatory insufficiency • Tenant C1 no is no longer residing at Oak Park Place 2. Measures taken to ensure the problem does not reoccur. • Staff will appropriately complete documentation as applicable as required by regulation. • Regional Nurse, Health Services Director, and direct care staff will be provided with specific education on documentation requirements for all routine personal care tasks identified on tenant's service plan. When tenant is no longer able to advocate on their behalf, tasks will be added to the Plan of Care for staff to document completion of task. • Staff will be educated on the importance of completing scheduled documentation for assigned tasks in the Plan of Care section of Point Click Care. 3. How the Program plans to monitor performance to ensure compliance. • Documentation will be reviewed Quarterly to ensure compliance with completion of scheduled tasks. Non-compliance with documentation requirements will be reviewed and re-education will be provided to ensure documentation completion. 4. The date by which the regulatory insufficiency will be corrected. • The Regulatory Insufficiency will be corrected on or before May 1, 2024	

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A 330	Continued From page 5 2023. On 1/17/24 at 11:15 am, the Regional Nurse confirmed the above gaps in documentation for Tenant C1.	A 330		
A 545	481-69.30(1) Dementia Specific Education for 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 3 of 4 staff reviewed received 8 hours of dementia-specific training with 30 days of employment (Staff C, Staff F, Staff G). Findings include: On 1/17/24 during a review of personnel records, the following information was found regarding dementia-specific training: - Staff C had a hire date of 9/22/23. Staff C had 4.5 hours of dementia-specific training on file as of 1/17/24. - Staff F had a hire date of 2/6/23. Staff F had 5 hours of dementia-specific training on file as of 1/17/24. - Staff G had a hire date of 12/12/22. Staff G had 6.25 hours of dementia-specific training on file as of 1/17/24. On 1/17/24 at 1:56 pm, the Director of Housing	A 545	481-69.30(1) Dementia Specific Education for Personnel- 69.30(1) All personnel employed by or contracting with a dementia specific program shall receive a minimum of 8 hours of dementia specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. 1. Elements detailing how the Program will correct each regulatory insufficiency. • Staff C, F, and G will receive appropriate training related to Dementia Education. 2. Measures taken to ensure the problem does not reoccur. • Director of Housing and Administrative Assistant will be provided with specific education on Dementia Specific Education Requirements for all new employees with 30 Day of Hire. 3. How the program plans to monitor performance to ensure compliance. • The program will monitor compliance by auditing employee files at least 2 times per year for 8 hours of Dementia Training within 30 days of hire. 4. Date by which the Regulatory Insufficiency will be corrected. • The regulatory insufficiency will be corrected on or before May 1, 2024	

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A 545	Continued From page 6 confirmed Staff C, Staff F, and Staff G had not completed 8 hours of dementia-specific training within 30 days of hire.	A 545		

✓ 6/27/24