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 09/11/2024

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: 18 Total census: 18 The following regulatory insufficiencies were cited during the investigation of Incident #122568-I and Incident #122589-I.	A 000		
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the program failed to follow the policy on Unintended Events for 1 of 1 tenants reviewed (Tenant 1). Findings include: 1. On 9/10/24 a review of incident reports revealed Tenant 1 eloped from the program's memory care unit on 8/5/24. The incident report indicated "no statements found" under the	A 125	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 09/11/2024

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 125	Continued From page 1 Statements category of the incident report. 2. On 9/10/24 at 9:12 am the Regional MDS Coordinator stated the program had no policy/procedure specifically addressing elopements/missing persons and the program's "Unintended Event" policy is used for elopements. A review of the policy instructed staff to complete an Incident Report as per policy. It further instructed for each unintended event to be fully investigated and depending on the type of event, the investigation would include resident/staff interviews (witness statements). 3. On 9/11/24 at 10:57 am the Regional MDS Coordinator stated the staff member who located Tenant 1 for the incident on 8.5.24 never wrote a statement regarding the incident. On 9/11/24 at 12 pm the Regional MDS Coordinator and Regional Nurse confirmed the above findings.	A 125		
A 638	481-69.32(4)b Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: b. Written procedures regarding appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the program failed to have a written procedure addressing appropriate staff response when a tenant's service plan indicated a risk of	A 638		

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 09/11/2024

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 638	Continued From page 2	A 638		

elopement or when a tenant exhibited wandering behavior for 1 of 1 current (Tenant 1) and 1 of 1 former (Tenant C1) tenants reviewed. Findings include:

1. On 9/9/24 a review of Tenant C1's record revealed an admission date of 6/4/24. A review of Tenant C1's service plan revealed the tenant was an elopement risk/wander due to cognitive deficits, identified/initiated on 5/30/24 as a focus area. The goal area was for the tenant to be provided with a safe and secure environment. Record review of the tenant's comprehensive assessment dated 7/2/24 further identified the tenant had a Global Deterioration Score (GDS) of 6 (severe cognitive decline) and wandering behaviors.

Incident reports revealed Tenant C1 eloped from the program on 8/2/24 and again on 8/3/24. The incident report dated 8/3/24 listed "wanderer" and "active exit seeker" as predisposing situation factors. The program completed a comprehensive assessment dated 8/9/24 as follow-up to the two elopement incidents. Item 13 on the comprehensive assessment identified the tenant as a wandering risk and the nurse review section of the comprehensive assessment further identified wandering behavior, but stated the tenant had no current exit seeking behaviors.

2. On 9/10/24 a review of Tenant 1's record revealed an admission date of 12/21/21. A review of Tenant 1's service plan revealed the tenant had a decline in cognition due to Alzheimer's disease, identified/initiated on 7/30/24 as a focus area. The goal area was for the tenant to be provided a safe and secure environment.

An incident report revealed Tenant 1 eloped from

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 09/11/2024

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 638	Continued From page 3 the program on 8/5/24. The incident report listed "wanderer" and "active exit seeker" as predisposing situation factors. The tenant's service plan was updated on 8/9/24 and included a focus area indicating the tenant's elopement risk/wander, history of wandering, and poor safety awareness and included new interventions (but not limited to) to document wandering behavior, to identify patterns of wandering, and to distract the tenant from wandering. The program completed a comprehensive assessment dated 8/9/24 as follow-up to address the elopement incident. Item 13 on the comprehensive assessment identified the tenant as wandering risk and the nurse review section of the comprehensive assessment further identified wandering behavior, but stated the tenant does not purposefully exit seek. 3. On 9/10/24 at 3:36 pm the Regional MDS Coordinator stated the program had no policies which addressed appropriate staff response when a tenant's service plan indicated a risk of elopement or wandering behavior. On 9/11/24 at 12 pm the Regional MDS Coordinator and Regional Nurse confirmed the above findings and acknowledged the concern could potentially affect all tenants residing in the program.	A 638		
A 639	481-69.32(4)c Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: c. Written procedures regarding appropriate staff response if a tenant with cognitive disorder or	A 639		

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 09/11/2024

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 639	Continued From page 4 dementia is missing. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the program failed to have a written procedure addressing appropriate staff response if a tenant with cognitive disorder or dementia was missing. Findings include: When asked for a written procedure regarding staff response if a tenant was missing on 9/10/24 at 9:12 am, the Regional MDS Coordinator stated the program had no policy/procedure specifically addressing elopements/missing persons and the program's "Unintended Event" policy was used for elopements. A review of the policy revealed the policy did not address appropriate staff response if a tenant with cognitive disorder or dementia is missing. On 9/11/24 at 12pm the Regional MDS Coordinator and Regional Nurse confirmed the above findings and acknowledged the concern could potentially affect all tenants residing in the program.	A 639		

Department of Inspections, Appeals, & Licensing
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 Recertification and Complaints #122568-I and #122589-I. The visit was conducted on 9/9/24 and 9/11/24. 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 conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

481-67.2(1)d Program Policies and Procedures - The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident.

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - 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.
    - Training has been conducted with leadership of the care team, ARMs on 09/18/24 and 10/9/24 about incident reporting and documentation.
    - ARMs will ensure that each incident that occurs on shift(s) gets reported timely through coaching and educating.
    - Each reporting shift coming on and going off will brief each other on incidents and follow up.
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 481-67.2(1) d related to Notification to the Department when a tenant elopes from the program.
    - ARMs will fill out daily reports to ensure all on shift tasks have been reported and completed.
3. How the program plans to monitor performance to ensure compliance.
    - The program will monitor compliance by auditing incident reports at least 4 times per year for compliance related to Notification to the Department.
    - Care staff will report an initial incident to nurse, then begin their incident reporting and proper documentation in PCC.
    - Incidents will be tracked through a binder with additional follow up.

4. Date by which the Regulatory Insufficiency will be corrected.
    - The Regulatory Insufficiency will be corrected on or before October 11,2024

5. Elements detailing how the Program will correct each regulatory insufficiency.
    - Director of Housing, Regional Nurse, and Health Services Director or Designee will train staff on program's "Unintended Event" policy for elopement
6. Measures taken to ensure the problem does not reoccur.
    - Notification to the Department when a tenant elopes from the program.
7. How the program plans to monitor performance to ensure compliance.
    - The program will monitor compliance by having drills at least 4 times per year for compliance related to Unintended Event.
8. Date by which the Regulatory Insufficiency will be corrected.
    - The Regulatory Insufficiency will be corrected on or before October 11,2024

481-69.32(4)c Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: c. Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing.

9. Elements detailing how the Program will correct each regulatory insufficiency.
    - Director of Housing, Regional Nurse, and Health Services Director or Designee will train staff on program's "Unintended Event" policy for elopement
    - These trainings will occur at the time of new hire and every 3 months during drills within the community.

10. Measures taken to ensure the problem does not reoccur.
    - Facility will have all new hires complete orientation with a tour in maintenance which will introduce them to fire safety, resident safety, and disaster preparation.
    - Service Plans will be updated with specific interventions identifying redirection techniques for all individuals identified as an elopement or wandering risk.

11. How the program plans to monitor performance to ensure compliance.
    - The program plans to monitor performance through drills that are conducted quarterly and with response times.
12. The date by which the regulatory insufficiency will be corrected.
    - Regulatory Insufficiency will be corrected on or before November 9, 2024

481-69.32(4)b Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: b. Written procedures regarding appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior.

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

- ARMs will be debriefed on new residents and current residents with their current or updated changes in elopement risk at daily meetings.
- There are wander books that have been created for each nurse station in the community, including kitchen to help identify residents with wandering tendencies.

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

- Staff will appropriately educate themselves on these residents who have wandering tendencies. They will know with the “lifestyle profiles” expressed by each resident the ways in which they can care for their needs.
- Doing frequent rounds and head counts. If there becomes an issue to report the concern to their supervisor and act immediately.

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

- Documentation will be reviewed weekly by the supervisor of ARMs and monitored for completeness and accuracy, regarding rounds, alarm checks, head counts, and incidents.

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

- The Regulatory Insufficiency will be corrected on or before November 9, 2024

Respectfully,

Rand Rasmussen, Director of Housing

Oak Park Place Memory Care