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 09/23/2021

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: 13 Total Census: 13 No regulatory insufficiencies were cited regarding Complaint 96787-C, Complaint 96470-C or the onsite infection control survey. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program and the investigation of Complaint #93153-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 interviews and record review the Program staff failed to ensure 1 of 7 tenants reviewed received services that were adequate and appropriate (Tenant # 5). Findings include: On 9/22/21, a review of Tenant #5's record revealed an admission date of 8/16/18. Tenant #5	A 160		

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A 160	Continued From page 1 had diagnoses including Alzheimer's disease, hypotension, syncope and collapse, hypothyroidism, hyperlipidemia, hypertension, nonrheumatic aortic valve stenosis, atrial fibrillation, GERD (gastroesophageal reflux disease), and peripheral vascular disease. A review of Tenant #5's service plan dated 3/30/21 revealed she received bathing assistance from staff two times a week. Staff assisted the tenant with getting in and out of the shower and washed her back and hard to reach areas. Documentation for bathing assistance revealed Tenant #5 had refused all shower assistance in the past 30 days (September 2021). On 9/21/21 at 12:22 pm, Staff A stated Tenant #5 usually refused her showers. She hated showers as well as staff completing hands-on cares. On 9/21/21 at 1:02 pm, Staff G stated Tenant #5 refused to shower and staff had no directives on how to help the tenant. On 9/28/21 at 12:15 pm, the Director of Housing and Director of Nursing confirmed the above finding.	A 160		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure 4 out of 9 staff	A 380		

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A 380	Continued From page 2 members reviewed completed dependent adult abuse training within 6 months of employment as indicated in Iowa Code section 235B.16 (Staff F, G, H, I) Findings include: Chapter 235 B requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment. A review of personnel records on 9/20/21 revealed the following: a.) Staff F was hired on 8/24/20. No dependent adult abuse training could be located with Staff F's personnel file. b.) Staff G was hired on 12/17/20. No dependent adult abuse training could be located with Staff G's personnel file. c.) Staff H was hired on 1/8/21. No dependent adult abuse training could be located with Staff H's personnel file. d.) Staff I was hired on 12/14/20. No dependent adult abuse training could be located with Staff I's personnel file. On 9/28/21 at 12:15 pm, the Director of Housing and Director of Nursing confirmed the above findings.	A 380		
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	A 145		

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A 145	Continued From page 3 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 ensure evaluations were completed as needed for 2 of 2 tenants reviewed who had experienced significant changes (Tenant #3, Tenant #7). Findings include: On 9/22/21 record review for Tenant #3 revealed an admission date of 2/25/21. Tenant #3 had diagnoses of dermatophytosis, benign neoplasm of colon, anemia, hyperlipidemia, dementia, hypertension, diverticulitis, cellulitis, seborrheic keratosis and chronic kidney disease. A review of nurse's notes revealed Tenant #3 was hospitalized from 7/15/21 to 7/20/21 for behavioral outbursts. No evaluations were competed prior to her return from the hospitalization which occurred due to a change of condition. On 9/22/21 record review for Tenant #7 revealed an admission date of 10/12/20. Tenant #7 had diagnoses of dementia, anemia, hyperlipidemia, heart failure, venous insufficiency, osteoarthritis and heartburn. A review of nurse's notes revealed Tenant #7 was hospitalized on 9/7/21 and 9/8/21 for a fracture of the sternum and other older fractures causing pain. Tenant #7 returned from the hospital with a new order for Tylenol. Tenant #7 had no evaluations completed prior to her return from her hospitalization.	A 145		

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A 145	Continued From page 4 On 9/28/21 at 12:15 pm, the Director of Housing and Director of Nursing confirmed the above findings.	A 145		
A 565	481-69.30(5) Dementia Specific Education for Personnel 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure 5 of 9 staff members reviewed received 8 hours of dementia-specific training that included hands-on instruction (Staff D, F, G, H, I) Findings include: On 9/20/21 during a review of personnel records, the following was discovered: a.) Staff D was hired on 6/15/21. Documentation showed Staff D had completed 4 hours of dementia-specific training on 6/17/21. There was no record of any hands-on training. b.) Staff F was hired on 8/24/20. Documentation showed Staff F had completed 4 hours of video training on 8/24/20. There was no record of any hands-on training. c.) Staff G was hired on 12/17/20. Documentation showed Staff G had completed 4 hours of video training on 12/18/20. There was no record of any hands-on training. d.) Staff H was hired on 1/8/21. Documentation showed Staff H had completed 4 hours of video training on 7/8/21. There was no record of any	A 565	Plan of Correction is attached	

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A 565	Continued From page 5 hands-on training. e.) Staff I was hired on 12/14/20. Documentation showed Staff I had completed 4 hours of video training on 12/16/20. There was no record of any hands-on training. On 9/28/21 at 12:15 pm, the Director of Housing and Director of Nursing confirmed the above finding.	A 565		

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 recertification report for the onsite visit between 09/20/2021 and 09/29/2021. 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.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant #5 will receive adequate and appropriate bathing services as outlined on their service plan.
    - The Director of Health Services and/or Nurse Designee will update the service plan for Tenant #5 to provide directives if bathing services are refused.
2. Measures taken to ensure the problem does not recur
    - Staff responsible for assistance with bathing will be provided re-education on tenant refusal of services.
    - Staff will have access to tenant service plan to guide care and services including interventions.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Health Services and/or Nurse Designee will review services/interventions every 90 days for tenants who receive assistance with ADL's.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before December 9, 2021.

Staffing

1. Elements detailing how the program will correct each regulatory insufficiency
    - Staff F, G, H, and I will complete required 2-hour Dependent Adult Abuse training.
2. Measures taken to ensure the problem does not recur
    - All staff will receive training related to identification and reporting of Dependent Adult Abuse within 6 months of initial employment as required by Iowa code Section 235B.16 and Chapter 235B.
    - If not completed within six months of employment, staff will be removed from the schedule until training is finished.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Housing and Director of Health Services will monitor completion of Dependent Adult Abuse training for all new employees and staff who do not complete within six months of hire will be removed from the schedule.

1/11/22

4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before December 9, 2021

Evaluation of a tenant

1. Elements detailing how the Program will correct each regulatory insufficiency
    - A significant change will be completed for Tenant #3 and Tenant #7. The regulatory insufficiency will be corrected on or before December 9, 2021.

2. Measures taken to ensure the problem does not recur
    - The Director of Health Services and/or Nurse Designee will be re-educated on regulatory requirements regarding completion of a significant change in condition.
3. How the Program plans to monitor performance to ensure compliance
    - Ongoing internal audits of tenant charts will be completed at least quarterly to ensure compliance of tenant evaluations.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before December 9, 2021

Dementia Specific Education for Personnel

1. Staff D, F, G, H, and I will complete 8 hours of Dementia Specific Education including hands-on training.
2. Measures taken to ensure the problem does not recur
    - All staff will receive a minimum of eight hours of dementia-specific education and training within 30 days of employment.
3. How the Program plans to monitor performance to ensure compliance
    - Ongoing internal audits of employee files will be completed at least every six months to ensure compliance of staff education requirements.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before December 9, 2021

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

Sincerely,

Elizabeth Greene DOH

Elizabeth Greene
Director of Housing