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
	S0418	A. BUILDING: _____ B. WING _____	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE	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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 33 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 33 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification for an Assisted Living Program: 231C.5 (1) Written occupancy agreement required. An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to execute written occupancy	A 000	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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A 000	Continued From page 1 agreements between the Program and tenants, or tenants' legal representative, prior to taking occupancy. This pertained to 4 of 4 tenants who resided in apartments intended for conversion to independent living (Tenants #4, #5, #6 and #7). Findings follow: Record review of documents (building layout and untitled documents) provided by the Program indicated the six apartments downstairs were under construction from May of 2017 through July of 2017 (assisted living apartments changed to independent living apartments). The tenant list provided by the Program reflected four tenants resided in the apartments intended for conversion to independent living apartments (Tenants #4, #5, #6 and #7). The ALP Entrance Form reflected the Program had a census of 33 tenants, including Tenants #4, #5, #6 and #7. The Program's current certificate reflected 48 units and the application dated 10-1-19 was for 48 assisted living dwelling units. A letter dated 11-7-19 from the Program confirmed six apartments were initially certified as assisted living apartments. It was requested the units be decertified from the certificate as of 11-7-19. When interviewed on 11-7-19 at 1:10 p.m. the Director of Maintenance said the six apartments (converted to independent living) had changes including the installation of a stove and dishwasher. Of the six apartments, three or four apartments were occupied. When interviewed on 11-7-19 at 2:50 p.m. the	A 000		

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A 000	Continued From page 2 Director of Housing revealed the tenants who resided in the apartments in the lower level (Tenants #4, #5, #6 and #7) had signed independent living contracts and did not have signed occupancy agreements for assisted living.	A 000		
A 059	481-67.9(4)b Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure nurse delegations were completed within 30 days of beginning employment for 2 of 4 staff reviewed employed greater than 30 days (Staff A and Staff C). Findings follow: Review of Staff A's file on 11-5-19 revealed a hire date of 12-3-18. Staff A's training on tasks including activities of daily living (ADLs) was completed on 1-22-19, which was not within 30 days of beginning employment. Review of Staff C's file on 11-5-19 revealed a hire	A 059		

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A 059	Continued From page 3 date of 7-30-19. Staff B's training on tasks including ADLs was completed on 9-6-19, which was not within 30 days of beginning employment. When interviewed on 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed all nurse delegation documents for the staff listed above were provided.	A 059		
A 149	481-67.9(6) Staffing 481-67.9(231B,231C,231D) Staffing. (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 staff completed training related to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16 for 2 of 2 staff reviewed employed longer than 6 months (Staff A, B). Findings include: Chapter 235B.16 requires employees to complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment. On 11-5-19 review of Staff A's file revealed a hire date of 12-3-18. No documentation of dependent adult abuse reported training could be located. On 11-5-19 review of Staff B's file revealed a hire	A 149		

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A 149	Continued From page 4 date of 3-11-19. No documentation of dependent adult abuse reported training could be located. On 11-7-19 at 1:39 p.m. the Director of Housing confirmed the required dependent adult abuse training was not completed for the staff listed above.	A 149		
A 029	481-69.19 Structural/Life Safety Rev. Prior to Remodel 481-69.19(231C) Structural and life safety review prior to the remodeling of a building for a certified program. 69.19(1) Before a building for a certified program is remodeled, the department shall review the blueprints for compliance with requirements set forth in rule 481-69.35(231C). Remodeling includes modification of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to notify the department of remodeling projects. Findings include: 1. Observation on 11-4-19 to 11-7-19 indicated current construction projects on the first floor and lower level of the building. 2. Review of documents (building layout and untitled documents) provided by the program indicated the following construction projects:	A 029		

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A 029	Continued From page 5 - Six apartments downstairs were under construction from May of 2017 through July of 2017 (assisted living apartments changed to independent living apartments). The work included electrical outlets of the stoves, flooring and countertops were replaced and an electric company installed an outlet for each dishwasher that was installed. The Director of Maintenance made the plumbing connections. Applicable permits were pulled; however, no plans were submitted to the state for review prior due to the cosmetic nature of the project. - Phase one, the pub/sitting area/cafe construction started March 2019. - Phase two, the movie theatre/community room and kitchen area construction started October 2019. - The movie theatre, salon, and waiting area were phase two of the pub/cafe remodel. A corporate project manager was checking with the architect to see if the Program received the exemption statement from the state for that portion of the work. 3. When interviewed on 11-7-19 at 1:10 p.m. the Director of Maintenance said the six apartments (converted to independent living) had changes including the installation of a stove and dishwasher and new electrical for the appliances by an outside electric company. There was construction that involved the cafe, salon and bank on the first floor. The construction on the movie theatre had just started. 4. A Building Modifications Request For Exemption From Full Plan Review document dated 9-20-17 indicated a description of the work indicated a remodel of lower level space into a pub and remodel of first floor space into a cafe.	A 029		

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A 029	Continued From page 6 The work was exempted from full plan review submittal, signed by the reviewing official on 9-26-17. No other exemption forms for the additional remodeling work was provided.	A 029		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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 or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not 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 3 tenants reviewed (Tenants #2 and #3). Findings follow: 1. Review on 11-7-19 of Tenant #2's file revealed Progress Notes indicating the following: - On 9-23-19 it was noted Tenant #2 returned from carpal tunnel surgery with an order for	A 037		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 037	Continued From page 7 Tramadol 50 milligram orally every six hours as needed. She also had a platform for her walker short term. - On 10-4-19 it was noted Tenant #2 was seen for a follow-up to carpal tunnel surgery. She could use her left hand as tolerated and was to slowly start weaning off of the platform on the walker. Review of the tenant's AL Comprehensive Assessment dated 11-6-19 revealed the nurse review was for a significant change as well as a missed assessment after carpal tunnel surgery. Evaluations were not completed as needed post surgery, including for the use of the platform walker, and with improvement including weaning off of the walker. 2. Review on 11-7-19 of Tenant #3's file revealed a Progress Notes dated 8-19-19 reflected a meeting was held regarding a possible increase in cares. Tenant #3 received assistance with bathing; however, it was not reflected in the service plan. It was requested staff assist with dressing of the lower body. The service plan would be updated to reflect the changes in bathing and dressing. Evaluations were not completed regarding these changes and increase in services. 3. On 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed all evaluation documents requested for the tenants listed above were provided.	A 037		
A 083	481-69.26(1) Service Plans	A 083		

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A 083	Continued From page 8 481-69.26(231C) 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 updated as required for 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Review on 11-7-19 of Tenant #1's file revealed an MD Notification Form dated 4-24-19 indicating Tenant #1 kept Loperamide capsules at bedside. An order was received for Tenant #1 to self-administer Loperamide 2 milligram (mg) for loose stools. A Doctor's Orders/Progress Notes document dated 10-27-19 reflected an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat. The tenant's most current signed service plan dated 12-27-18 was not updated to include the self-administered and stored Loperamide or the PT/OT services. 2. Review on 11-7-19 of Tenant #2's file revealed	A 083		

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A 083	Continued From page 9 an AL Comprehensive Assessment dated 3-7-19 for re-admission from a nursing facility following a left wrist and pelvic fracture from a fall on 2-3-19. Tenant #2 was to receive PT and OT on an outpatient basis. A signed service plan was not found for Tenant #2's return to the Program from the nursing facility. Review of Progress Notes indicated the following: - On 9-23-19 it was noted Tenant #2 returned from carpal tunnel surgery with an order for Tramadol 50 milligram orally every six hours as needed. She also had a platform for her walker short term. - On 10-4-19 it was noted Tenant #2 was seen for a follow-up to carpal tunnel surgery. She could use her left hand as tolerated and was to slowly start weaning off of the platform on the walker. Review of the tenant's AL Comprehensive Assessment dated 11-6-19 revealed the nurse review was for a significant change as well as a missed assessment after carpal tunnel surgery. The service plan was not updated as needed post surgery to reflect Tenant #2's needs including for the use of the platform walker, and with improvement including weaning off of the walker. 3. Review on 11-7-19 of Tenant #3's file revealed a Progress Notes dated 8-19-19 reflected a meeting was held regarding a possible increase in cares. Tenant #3 received assistance with bathing; however, it was not reflected in the	A 083		

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A 083	Continued From page 10 service plan. It was requested staff assist with dressing of the lower body. The service plan was updated to reflect the changes in bathing and dressing; however, the service plan was not based on evaluations as evaluations were not completed. 4. When interviewed on 11-7-19 at 2:14 p.m. the Director of Healthcare Services revealed all service plan documents requested for the tenants listed above were provided.	A 083		
A 115	481-69.29(1) Staffing 481-69.29(231C) Staffing. In addition to the general staffing requirements in rule 481-67.9(231B,231C,231D), the following requirements apply to staffing in programs. 69.29(1) Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide access to a 24-hour personal emergency response system for 4 of 4 tenants residing in apartments intended for conversion to independent living apartments (Tenants #4, #5, #6 and #7). Findings follow: Record review of documents (building layout and untitled documents) provided by the Program indicated the six apartments downstairs were under construction from May of 2017 through July of 2017 (assisted living apartments changed to independent living apartments).	A 115		

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A 115	Continued From page 11 The tenant list provided by the Program reflected four tenants resided in the apartments intended for conversion to independent living apartments (Tenants #4, #5, #6 and #7). The ALP Entrance Form reflected the Program had a census of 33 tenants, including Tenants #4, #5, #6 and #7. The Program's current certificate reflected 48 units and the application dated 10-1-19 was for 48 assisted living dwelling units. A letter dated 11-7-19 from the Program confirmed six apartments were initially certified as assisted living apartments. It was requested the units be decertified from the certificate as of 11-7-19. When interviewed on 11-7-19 at 1:10 p.m. the Director of Maintenance said the six apartments (converted to independent living) had changes including the installation of a stove and dishwasher. Of the six apartments, three or four apartments were occupied. The tenants in the those apartments did not have pendants or pull cords. When interviewed on 11-7-19 at 1:39 p.m. the Director of Housing revealed the tenants (Tenants #4, #5, #6, and #7) who resided in the apartments in the lower level did not have pendants or pull cords.	A 115		

1/7/20

December 18, 2019

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, Iowa, I respectfully submit our Plan of Correction for your approval. Our response is specific to the certification visit report for November 7, 2019, onsite visit. 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 provisions of Iowa law.

Occupancy Agreement

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenants #4, #5, #6 & #7 no longer reside in Assisted Living
    - All future tenants will sign/date an occupancy agreement in accordance with regulatory requirements prior to taking occupancy of the apartment.

2. What measures will be taken to ensure the problem does not recur.
    - The Executive Director will be re-educated on regulatory requirements for initiating an occupancy agreement.

3. How the Program plans to monitor performance to ensure compliance.
    - The Executive Director and/or Designee will audit tenant charts at least annually to ensure an occupancy agreement was signed/dated as required by regulation.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The RN will review delegated training specific to Staff A and C. Delegations will be reviewed and completed as appropriate. Staff A's last day of employment at Oak Park Place is 12/27/19.
    - Staff A and B will complete required Dependent Adult Abuse Training. Staff A's last day of employment at Oak Park Place is 12/27/19.
    - All tenants will have access to an emergency pendant or pull cord.

1/3/20

2. What measures will be taken to ensure the problem does not recur.
    - All nursing staff will receive appropriate training/delegations within 30 days of hire by the RN.
    - The RN will ensure that staff have appropriate training/delegation prior to completing tasks.
    - All staff will receive Dependent Adult Abuse training within 6 months of hire and ongoing as required by regulation.
    - Administration, RN, and Marketing will be educated on regulatory requirements related to access of emergency pendant system.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will review staff files at least two times per year to ensure staff has appropriate training/delegations on file.
    - Emergency pendants and/or pull cords will be tested at least two times per year to ensure they are operating per manufacturer specifications.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Structural/Life Safety

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Architectural plans have been submitted to the State Fire Marshall for review.

2. What measures will be taken to ensure the problem does not recur.
    - The Department will be notified in advance of all future re-modeling and construction projects.

3. How the Program plans to monitor performance to ensure compliance.
    - Corporate Entity Administrator/Designee will review annually to ensure compliance

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenants #2 and #3 will have evaluations completed by the RN.
    - Tennant #3 no longer resides at Oak Park Place.
    - The RN will complete evaluations as required when all tenants have a significant change in condition.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated on regulatory requirements for evaluation of tenants, including identifying potential changes in condition.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will review tenant files at least every 90 days to ensure evaluations are completed as required by regulation and that evaluations are reflective of the tenant.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Service Plan

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenants #1, #2 and #3 will have service plans updated by the RN. Service plans will identify tenant needs and preferences for assistance as well as any outside service providers.
    - Tennant #3 no longer resides at Oak Park Place.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and/or Designee will be re-educated on regulatory requirements for service plan development.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will review tenant files at least every 90 days to ensure service plans identify tenant needs, preferences for assistance and outside service providers.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance on or before January 10, 2020.

Please contact me at 563-543-5119 with any questions you have. Thank you.

Sincerely,

Cheryl Scheele
Executive Director