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 _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE AL	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: 37 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 37 No regulatory insufficiencies were cited during the onsite infection control survey. The following regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program.	A 000	Plan of Correction is attached	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure its Emergency Call System policy was consistently followed for 1of 4 current (Tenant #2) and 1of 1 former (Tenant C1) tenants reviewed. Findings include: On 9/22/21 a review of pendant calls by Tenant C1 for the month of September 2021 revealed the following response times over 15 minutes: - 9/1/21: pendant pushed at 5:29 am. Staff responded to the call in 40 minutes and 33 seconds. - 9/3/21: pendant pushed at 8:24 pm. Staff responded to the call in 34 minutes and 29	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 1 seconds. - 9/8/21: pendant pushed at 7:32 am. Staff responded to the call in 19 minutes and 15 seconds. - 9/10/21: pendant pushed at 5:18 pm. Staff responded to the call in 21 minutes and 36 seconds. - 9/10/21: pendant pushed at 7:13 pm. Staff responded to the call in 16 minutes and 20 seconds. On 9/27/21 a review of pendant calls by Tenant #2 for the month of September 2021 revealed the following response times over 15 minutes: - 9/1/21: pendant pushed at 3:39 am. Staff responded to the call in 2 hours, 34 minutes and 6 seconds. - 9/2/21: pendant pushed at 9:44 pm. Staff responded to the call in 23 minutes and 16 seconds. - 9/3/21: pendant pushed at 2:18 am. Staff responded to the call in 16 minutes and 19 seconds. - 9/3/21: pendant pushed at 6:08 am. Staff responded to the call in 21 minutes and 6 seconds. - 9/5/21: pendant pushed at 8:25 pm. Staff responded to the call in 19 minutes and 45 seconds. - 9/10/21: pendant pushed at 5:08 pm. Staff responded to the call in 29 minutes and 20 seconds. - 9/10/21: pendant pushed at 6:04 pm. Staff responded to the call in 20 minutes and 59 seconds. On 9/27/21, a review of the Program's Emergency Call System policy revealed the following standard of care outlined: "Pendants need to be answered in a timely manner.	A 150		

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A 150	Continued From page 2 Acceptable Call Pendant is considered to be less than 10 minutes. If for some reason the Pendant was not answered in a timely manner and it was beyond 10 minutes this needs to be communicated to your ARM/Team Lead." Attached to the Emergency Call System policy was a Pendent Exception form to be completed and given to a supervisor when pendant responses were longer than 10 minutes. A review of Pendant Exception forms revealed only one form competed for September 2021(9/1/21 for Tenant #2). On 9/28/21 at 12:15 pm, the Director of Housing and the Director of Nursing confirmed the above calls were beyond the standard of care expected by the Program's policy and only one exception form was completed for September.	A 150		
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 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	A 380		

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A 380	Continued From page 3 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 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.	A 145		

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A 145	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure evaluations were completed with significant change for 1 of 1 former tenants reviewed (Tenant C1). Findings include: On 9/22/21 record review for Tenant C1 revealed an admission date of 8/9/21. Tenant C1's last cognitive, health and functional evaluations were conducted on 8/2/21 for initial services while still living at home prior to her admit to the Program. The evaluations completed on 8/2/21 showed the following summary of Tenant C1's needs: "[Tenant C1] is independent with transfers, eating, dressing, etc. [Tenant C1] is steady with ambulation when she has her walker and is walking around the house. When she is going long distances or going to be out of the house for an extended period of time, she has a wheelchair that she uses. [Tenant C1] is oriented and alert X 4. [Tenant C1] needs minimal assistance with showing as she cannot complete the entire ADL independently." A nurse's note dated 9/14/21 (more than 30 days after admission), showed the following concern: "Resident is refusing to eat more than a couple bites and is refusing ensure. Resident has not consumed any food thus far today. [Tenant C1's] son has tried and so has staff. This writer (Director of Nursing) called PCP office to discuss this and they are going to call back." On 9/27/21 at 12:28 pm, the Director of Nursing stated Tenant C1 was not eating on Tuesday, September 14th or Wednesday, September 15th. The Director of Nursing stated she contacted Tenant C1's primary care physician who	A 145		

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A 145	Continued From page 5 questioned if hospice was not the right route for Tenant C1. The Director of Nursing stated she immediately had spoken with Tenant C1's emergency contact, her son, regarding the physician's suggestion. The son wanted to discuss this with his other siblings on Friday, September 17th. On 9/27/21 at 12:45 pm, Staff K stated Tenant C1 used to tell people what she needed and was able to walk on her own using her walker. Staff K stated that in days prior to 9/16/21 when Tenant C1 passed away, she was having difficulties walking alone and wasn't eating very well. Tenant C1 did not have cognitive, health, and functional evaluations completed when significant changes of refusing to eat and assistance needed with ambulation were noted by Program staff and the Director of Nursing. On 9/28/21 at 12:15 pm, the Director of Housing and Director of Nursing confirmed the above finding.	A 145		
A 300	481-69.25(1)k Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: k. Advance health care directives as applicable This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure advanced health care directives were on file for 1 of 1 former tenants reviewed (Tenant C1). Findings include: On 9/22/21 during a review of incident reports, a staff statement/incident report was discovered	A 300		

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A 300	Continued From page 6 regarding the death of Tenant C1 on 9/16/21. The documentation showed Tenant C1 pushed her pendant around 6:15 am and Staff K responded. Staff K had difficulty understanding what Tenant C1 was saying. Staff K requested Staff G's assistance. Staff K and Staff G assisted Tenant C1 to the toilet. Tenant C1 went unresponsive while on the toilet and Staff K called 911. Paramedics were summoned, but in the meantime, the 911 operator instructed staff to place the tenant on the floor and begin CPR (cardio pulmonary resuscitation). At the same time, Staff G called the Director of Nursing per policy. Staff G performed CPR for 9 minutes until paramedics arrived. Paramedics inquired about DNR (do not resuscitate) status with staff and the Director of Nursing over the phone, but there was no paperwork on file yet since the tenant's admission on 8/9/21. Paramedics used all measures to revive Tenant C1 since there was no DNR paperwork on site. Tenant C1 was taken to the hospital. Tenant C1 passed away later in the day on 9/16/21 surrounded by her family and hospice. On 9/21/21 at 1:02 pm, Staff G stated she assisted Tenant C1 to the toilet with Staff K on the morning of 9/16/21. Staff G confirmed Tenant C1 went unresponsive while on the toilet. Staff K called 911 and staff were instructed to place Tenant C1 on the floor and begin CPR. Staff G performed CPR for 9 minutes until paramedics arrived. Staff G stated she called Tenant C1's son to let him know the paramedics had taken his mother to the hospital. She stated the son was very upset because his stated his mother had a DNR status. Staff G explained that because the Program did not have the actual paperwork on file, the paramedics had to take her.	A 300		

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A 300	Continued From page 7 On 9/27/21 at 12:28 pm, the Director of Nursing confirmed she was called during the incident on 9/16/21. The Director of Nursing confirmed the Program did not have the advance directives paperwork on file for Tenant C1. The Director of Nursing stated Tenant C1's son indicated he would meet the paramedics at the hospital with the DNR paperwork. Tenant C1 was returned to the Program on 9/16/21 at around 1:30 pm with her family and hospice. Tenant C1 passed away at around 2:20 pm. On 9/28/21 at 12:15 pm, the Director of Housing and Director of Nursing confirmed the above finding.	A 300		

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 Assisted Living 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.

Program Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant emergency pendants will be answered in a timely manner according to the Emergency Call System Policy.
2. Measures taken to ensure the problem does not recur
    - Staff education will be provided on the Emergency Call System Policy
    - Calls unanswered after 10 minutes will escalate to the Director of Health Services and the Director of Housing
3. How the program plans to monitor performance to ensure compliance
    - Ongoing internal audits of call response times will be completed by the Director of Housing and/or the Director of Health Services at least every six months.
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.
    - 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 employment date will be removed from the schedule.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before December 9, 2021

11/11/21

Evaluation of a Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency
    - A significant change of condition assessment will be completed for any tenant noted to have a major decline or improvement in status.
2. Measures taken to ensure the problem does not recur
    - The Director of Health Services and/or RN 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

Tenant Documents

1. Elements detailing how the Program will correct each regulatory insufficiency
    - A tenant's Advance Directive or physician order regarding Code Status will be followed by staff.
    - The Director of Housing, the Director of Health Services and/or Nurse Designee will review all tenant charts to ensure the Program has Advanced Directives on file as applicable.
    - Advance Directive or physician order regarding Code Status will be requested from tenant and/or POA upon admission.
2. Measures taken to ensure the problem does not recur
    - The tenant's Advanced Directive including code status of DNR or Full Code will be accessible to staff for review as needed.
    - All staff will be provided re-education on Advance Directive Policy
3. How the Program plans to monitor performance to ensure compliance
    - Ongoing internal audits of tenant charts will be completed at least every six months to ensure Advance Directives are available as applicable.
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