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
	S0348	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE POINTE PLACE	2700 MATTHEW JOHN DRIVE DUBUQUE, IA 52002

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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 impairment: 85 Number of tenants with cognitive impairment: 4 Total census: 89 The following regulatory insufficiencies were cited during the investigation of Incident #123945-I, Incident #123685-I and Complaint #123922-C.	A 000		
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 interviews and record reviews, staff failed to follow the Program's established policies regarding medication administration for 2 of 4 tenants reviewed (Tenant #1, Tenant #2). Findings include: 1. On 10/14/24, a review of Tenant #1's record revealed an incident report dated 10/8/24. The incident report revealed Staff E was called to Tenant #2's apartment on 10/8/24 at 8:00 am and was told by Tenant #2 she had received a cup of someone else's medications from Staff C during the morning medication pass. Staff E took the cup of medications to the Assistant Director of	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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Health Services (ADHS). The medications were compared to medication administration records and were found to be Tenant #1's morning medications. Upon assessment, Tenant #1 was discovered to have received Tenant #2's morning medications and appeared lethargic. Tenant #1 was given the following medications that belonged to Tenant #2: Aspirin 81 mg, Diltiazem 180 mg, Ferrous Sulfate 325 mg, Furosemide 20 mg, Levetiracetam 750 mg, and Potassium 10mEq.

The hospital report dated 10/8/24-10/9/24 revealed Tenant #1 received sodium chloride 0.9% bolus 500 mL and calcium chloride 10% injection to counter the ingested medications. Tenant #1 was also given oxygen via mask due to an oxygen level of 86%. Poison control was consulted and was instructed to observe for 12-24 hours. The discharge diagnosis on 10/9/24 was accidental drug ingestion, chronic obstructive pulmonary disease, acute metabolic encephalopathy, arteriosclerotic cardiovascular disease, dyslipidemia and primary hypertension. There were no new orders at discharge except to follow up with the primary physician.

2. On 10/10/24 at 2:10 pm, the ADHS stated Staff E gave her a cup of medications and reported Tenant #2 had given them to her saying Staff C had left the cup of medications for her to take. Tenant #2 had told Staff E they were not her medications and that she knew what pills she took. Tenant #2 has also stated she had already taken one of the tablets when she realized the rest of the medications were not hers. The ADHS immediately compared the cup of pills to the medication administration record and discovered the medications in the cup belonged to Tenant #1. She noted one tablet was missing from the cup

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A 150	Continued From page 2	A 150		

that Tenant #2 ingested. This was a Calcium/D3 600 mg-5 mcg tablet which Tenant #2 was scheduled to have later in the day and could be held.

The ADHS immediately spoke with Tenant #2 who with no concerns. She then assessed Tenant #1. Tenant #1's vitals were within normal limits, however she appeared lethargic with slightly slurred speech. The ADHS stated Tenant #1 used 2L of oxygen continuously via nose canula and often would take her oxygen off, or not realize her battery was not charged, which could also cause lethargy. The tenant's physician and family were notified. Per physician's instruction, Tenant #1 was sent to the emergency room for evaluation. The hospital informed the Program Tenant #1 was stable and was going to be observed overnight.

The ADHS interviewed Staff C regarding her medication pass. Staff C stated she was not aware of how the mistake was made as she popped the pills individually per tenant and took them into the apartments one at at time. The Assistant Director of Health Services stated she pulled Staff C from medication administration duties and she was no longer allowed to pass medications for the Program.

3. On 10/14/24 at 10:00 am, Staff C stated she passed medications to Tenant #1 and Tenant #2 on 10/8/24. Staff C stated she passed Tenant #1's medications before Tenant #2's. She had not realized she had made a mistake until the ADHS questioned her. Staff C stated she took each person's medications individually into their rooms. When she administered Tenant #2's medications, she always left them on her table to take later and did not watch her ingest them. Staff C stated she

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A 150	Continued From page 3 was busy that day and must have mixed up the two rooms. 4. When interviewed on 10/15/24 at 11:08 am, Staff D stated she was also a medication manager on 10/8/24. Staff D told the ADHS on 10/8/24 that Staff C had explained to her she had pre-popped both tenant's medications and placed them in cups with the room numbers written on the cups. Staff C told her she must have given the tenants the wrong cups. Staff D stated she observed Staff C pre-pop medications into cups, write room numbers on them, stack them all together, and go down the hall to pass them. Staff D stated she told Staff C many times she should not do that and it was not the correct practice of passing medications. The correct method was to take the cart to each individual room, ensure the tenant was home, pop the pills into a cup, take them in and watch them ingest. 5. On 10/14/24 at 10:16 am, the Director of Health Services (DHS) stated she had given Staff C at least two verbal warnings in the past about not pre-popping medications and stacking cups together before administering to tenants. At the emergency room, Tenant #1 had a blood pressure of 100/68 and her oxygen was at 91% around 9:00 am. Her lab work was also normal. The DHS stated Tenant's blood pressure dropped to 92 over 71 at 12:30 pm. One of the medications Tenant #1 ingested was diltiazem 180 mg ER which was taken for hypertension and would lower blood pressure. Had the Program not sent Tenant #1 to the emergency room for treatment she may not have made it. 6. On 10/10/24, a review of the Program's Medication Administration and Medication Documentation policies were reviewed. The	A 150		

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A 150	Continued From page 4 Medication Administration policy revealed the seven "rights" of medication administration were to be observed every time a medication was administered. Two of these rights were the right person and the right medications. Staff C failed to follow the Program's policy by not following the seven "rights" of medication administration for both Tenant #1 and Tenant #2 on 10/8/24. The Medication Documentation policy revealed staff were to observe the tenant taking the medication(s) prior to documenting the administration on the medication administration record. Staff C failed to observe Tenant #2 take her medications but left them for her to take at a later time. 7. On 10/15/24 at 3:30 pm, the Executive Director and Director of Health Services confirmed the above findings.	A 150		
A 361	481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interviews and record reviews, staff failed to provide services in accordance to training for 2 of 4 tenants reviewed regarding medications (Tenant #3, Tenant #4). Findings	A 361		

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A 361	Continued From page 5 include: 1. On 10/10/24, a review of an internal investigation completed by the Assistant Director of Health Services (ADHS) regarding a shift change narcotic count by Staff A and Staff B revealed the staff found discrepancies in the count. The discrepancies were identified in Tenant #3 and Tenant #4's narcotic medications. 2. On 10/10/24 at 2:10 pm, the ADHS stated she received a call at around 10:30 pm on 9/16/24 from Staff A regarding a discrepancy in the narcotics. Staff A reported to her only that Tenant #4 was missing one narcotic pill, a Lorezepam 0.5 mg tablet. The next morning an internal investigation was completed which included 2 sets of interviews. The ADHS stated her first set of interviews revealed first shift completed a narcotic count with second shift on 9/16/24 and counted 18 tablets of Lorezepam for Tenant #4. During the narcotic count at shift change between second shift and third shift, only 16 tablets were counted with one tablet being given at the 8 pm medication pass. This resulted in Tenant #4 being short one tablet. After talking to different staff members and the story being changed, the ADHS conducted a second round of interviews. Upon interviewing staff a second time, it was found Staff A and Staff B originally found Tenant #4 was in fact missing one Lorezepam 0.5 mg tablet, but Tenant #3 had an extra Lorezepam 0.5 mg tablet during the same med count. Staff B was the third shift staff and told Staff A she would not sign off on the count because it was incorrect. Staff B later told the ADHS in interview that she observed Staff A pop out the extra Lorezepam tablet out of Tenant #3's medication card and destroy it using the	A 361		

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A 361	Continued From page 6 Drug Buster destruction tool. An interview with Staff I revealed she had also observed Staff A destroy a medication in the drug buster around shift change. Staff A admitted to the ADHS that she had indeed destroyed Tenant #3's extra Lorezepam but stated other staff had told her to do so. She also failed to mention she destroyed the medication when she called to inform the nurse of the discrepancy. Staff A and Staff B were terminated from employment as a result of the investigation. It was believed Staff A destroyed Tenant #3's extra Lorezepam tablet to hide the fact that she likely gave both Tenant #3 and Tenant #4 the correct dose of Lorezepam at the 8 pm medication pass but administered both tablets from Tenant #4's packet and failed to use the packet for Tenant #3 which resulted in him having an extra. Staff A wanted to only report the missing tablet from Tenant #4's packet which would not necessarily point at her as making a mistake. 3. On 10/15/24 at 2:05 pm, Staff I stated she was present during the narcotic count between Staff A and Staff B on 9/16/24. Staff I stated she had walked into the medication room and observed Staff A placing a pill into the drug buster system. She asked Staff A what she was doing and what the medication was. Staff I stated Staff A's response was "no biggie." 4. On 10/15/24, a review of personnel records revealed Staff A was trained on Narcotic Counts as part of the Registered Nurse delegations on 7/9/24 and Staff B was trained on Narcotic Counts as a part of the Registered Nurse delegations on 7/11/24. The Narcotic Count procedures detailed if staff find that counts are off or staff do not agree on counts, the on-call	A 361		

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A 361	Continued From page 7 registered nurse should be contacted immediately for direction. Staff A did not follow the Narcotic Count training as she chose to dispose of a tenant medication prior to calling the registered nurse on-call and failing to report her actions. 5. On 10/15/24 at 3:30 pm, the Executive Director and Director of Health Services confirmed Staff A had not followed the training she was provided regarding narcotic counts as a part of nurse delegations.	A 361		