| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165372 | A. BUILDING _____ B. WING _____ | C 12/27/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ELM CREST RETIREMENT COMMUNITY | 2104 12TH STREET HARLAN, IA 51537 |

| (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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Correction date 1/21/2017<br><br>Investigation of facility-reported incident #64539-I resulted in deficiency.<br><br>See the Federal Code of Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 333 SS=G | 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, facility policy, and staff interviews, the facility failed to administer all medications as ordered by the physician for one of four residents (Resident #1). The facility reported a census of 63 residents.<br><br>Findings include:<br><br>1. Review of the face sheet for Resident #1 revealed the resident 87 years old and diagnoses to include; muscle weakness, presence of a cardiac pacemaker, syncope and collapse, history of falling, major depressive disorder, Atrial fibrillation, hypertension, diabetes mellitus, hypothyroidism, iron deficiency anemia, insomnia and glaucoma.<br><br>Review of the Minimum Data Set (MDS) for Resident #1 dated on 11/22/16 revealed a Brief Interview for Mental Status score of 11 (represents moderately impaired cognition).<br><br>Review of the nurses notes for Resident #1 dated | F 333 | See Attached | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Timothy J Nausler | Administrator | 1/20/2017 01/11/2017 |

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| F 333 | Continued From page 1<br>Interview for Mental Status score of 11 (represents moderately impaired cognition).<br><br>Review of the nurses notes for Resident #1 dated on 11/29/16 at 9:58 AM revealed; Resident was given another resident's morning medications [Resident #2] by mistake. The pharmacy had been called regarding side effects for Clozapine 200 milligram (mg) dose and Seroquel 75 mg dose.<br>The progress notes reported identified the medication/s may cause increased drowsiness and dizziness. Staff took Resident #1 back to his/her room via wheelchair. The resident is unresponsive and drooling from side of mouth. The resident does not open eyes when spoken to, color pale, temperature 97 degrees, pulse 60 beeps per minute, respiratory rate at 8 and blood pressure 68/no read. Oxygen saturation at 96% while on room air. 911 called and taken to Emergency (ER).<br><br>The ambulance report dated 11/29/16 documented at 9:34 a.m. dispatched for an 87 year old who was given the incorrect medications, and had a sharp decrease in mental status, needing a transport from the nursing home.<br><br>Review of the medical center History and Physical dated 11/30/16 revealed accidental ingestion of high-dose Seroquel and Clozapine. Admitted into acute care in stable but guarded condition. The resident was initially admitted for observation but due to persistent mental status changes will be admitted for acute care. The physician documented he reiterated to the family the changes are most likely related to the medications [accidental ingestion]. Due to the resident ' s age and slow metabolism, it will take | F 333 | | |

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| F 333 | Continued From page 2 | F 333 | | |

pneumonitis. The report documented the current medications as follows: alprazolam for anixety.5 mg 1 p tablet (tab) prn (as needed); Colace 100 mg daily; Tylenol 500 mg 1-2 every 4-6 hours prn; ferrous sulfate 325 mg daily; calcium carbonate with vitamin D 1 tab daily; Eliquis 5mg twice daily; levothyroxine 112 mcg daily; citalopram 10 mg daily; simvastatin 10 mg daily; and eye drops.

Review of the Medication Administration Record (MAR) for Resident #1 revealed the AM medications that had not been given the morning of 11/29/16 are: Acetaminophen 500 mg 2 tablets (pain), Celexa 5 mg (anti-depressant), colace 100 mg 1 capsule (stool softener), Eliquis 5 mg 1 tablet (heart drug), Midodrine hydrochloride 10 mg (heart drug).

Review of the Medication Administration Record for Resident #2, (the record of medications that was given to Resident #1 by mistake) revealed the following medications ordered at 8 AM, Metoprolol Succinate ER 25 mg by mouth, Seroquel 75 mg by mouth, Aleve 220 mg and Clozapine 200 mg by mouth and Synthroid 50 mcg by mouth ordered to be given at 7 AM.

Review of the Medication Error Report dated 11/29/16 for Resident #1 revealed the following medications given to the resident by mistake: Metoprolol Succinate ER 25 mg (high blood pressure medication), Multivitamin, Seroquel 75 mg (antipsychotic medication), Synthroid 50 mcg (micrograms, thyroid hormone replacement), Aleve 220 mg (anti-inflammatory), Clozapine 200 mg (antipsychotic medication).

An untitled form from the facility dated 12/1/16



TJN

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| F 333 | Continued From page 3<br>Aleve 220 mg (anti-inflammatory), Clozapine 200 mg (antipsychotic medication).<br><br>An untitled form from the facility dated 12/1/16 documented an update that the resident had been given antibiotics for aspiration pneumonia. The physician assistant reported it will be 2-3 days and they are just waiting for his/her liver and kidneys to clear and they had been in contact with poison control daily.<br><br>The nursing home progress noted dated 12/5/16 documented the resident returned from the hospitalization with a diagnosis of aspiration pneumonia.<br><br>During an interview on 12/19/16 at 1:49 PM, Resident #1's primary care physician stated it was a major injury and would have died if the facility had not acted right away.<br><br>During an interview on 12/6/16 at 10:20 AM, Staff A, Licensed Practical Nurse (LPN) stated she was at her med cart that morning 11/29/16 setting up medications for Resident #2 when her grandmother Resident #1 entered and said good morning, she then picked up the med cup that had medication for Resident #2 and gave them to her grandmother without thinking. She stated when she returned to her med cart, she realized what she had done because Resident #2's medication record was up on her screen. She explained it to her grandmother and her supervisor right away. She spoke to her supervisor and before Resident #1 finished breakfast he/she had a change of condition, taken back to his/her room, 911 had been called and sent out to the ER. She stated since the incident, all the nurses have reviewed the 6 rights | F 333 | | |

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| F 333 | Continued From page 4 | F 333 | | |

unavoidable interruptions in the facility she always will double check the medications in the med cup against the MAR just before she administers them to the resident. She stated that the nurses are always thinking and planning two steps ahead and they have other resident names in their head, so they have to be careful for their own safety.

During an interview on 12/7/16 at 11:30 AM, Staff D, RN stated they are expected to follow the 6 rights of medication administration, never click off their MAR with photo until they have it completed. They are able to lock the screen so no one can see it, but the person they are giving med's to is still on the screen when it is unlocked.

During an interview on 12/7/16 at 11:40 AM, Staff C, RN stated she will always leave the resident she is giving med's to locked up on her screen and she will leave it there until she has completed the medication administration, then she will sign them off when finished. If she is interrupted, she will lock the cart, lock the screen, leave and complete what was needed then she can bring up the same person she had up just before walking away.

During an interview on 12/7/16 at 11:15 AM, Staff E, LPN stated she will always do one at a time, do her best not to be interrupted but if she is, she will lock the cart, the screen and the person she had been working on prior will still be on the MAR, she then will review the MAR and take it from there.

Review of the Medication Administration Policy & Procedure revealed the following procedure;
1. wash hands,



TJN

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| F 333 | Continued From page 5<br><br>Review of the Medication Administration Policy & Procedure revealed the following procedure;<br>1. wash hands,<br>2. bring the med cart to where the medications are to be administered,<br>3. check the electronic medication administration record (e-mar),<br>4. read the order entirely,<br>5. remove the medication<br>6. if any discrepancy, check the physician's order,<br>7. if the label is wrong, check with the pharmacy,<br>8. use appropriate measuring device and read all special instructions,<br>9. check the appearance of the drug, crush only when indicated,<br>10. initial the e-mar as each medication is removed from the cassette,<br>11. identify each resident by checking the picture in the e-mar,<br>12-26. (did not apply in this incident) | F 333 | | |

**Elm Crest Retirement Community**
**License #830051, Provider/Supplier/CLIA #165372**
**Harlan, Iowa 51537**

**Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.**

**The following is to be considered our Credible Allegation of Compliance**

**F 333 Residents Free of Significant Medication Errors**

Correct Deficiency to Individual:
Resident was sent to hospital for treatment. Nurses and Medication aides have been re-educated on medication administration. Staff nurse making error was re-educated and sent home prior to end of shift.

Protect Residents in Similar Situations:
Nurses and Medication aides have been re-educated on medication administration. As nurses and med aides came on following shifts, they were re-educated and reviewed the medication administration.

Measure/System to prevent reoccur:
All nurses and Medication Aides will have re-education on the medication administration. This will be completed by 12/2/2016. A Med Administration review was done during Medication Aide and Aide meeting on 12/13/2016 and at Nurses meeting on 12/14/2016. In addition Medication Administration interruptions was discussed at All Staff Meetings on 12/8/2016 and 1/12/2017 as well as at our Team Time, 2X/day, at various days each week in December and in January

Monitor Permanent Solution:
Director of Nursing/designee will do weekly audits during the first four weeks of three medication passes by nurses or medication aides. DON/Designee will then continue to do an audit for another four weeks on one medication pass by either a nurse or medication aide. Any negative audits will be taken to the monthly QAPI meeting and evaluated for compliance at our next 2 meetings.

**Completion Date of January 21, 2017**