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Citation Number: 6978					Date: May 23	, 2019
Facility Name: Rose Vista			Survey Dates: April 22-25, 2019			
Facility Address/City/State/Zip 1109 Normal St.						
Woodbine, IA		JM				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount		Correction date
58.19(2)a 58.20(1)a	residents. The resident facility shall provide, a required nursing servidirection of qualified roverage as set forth 58.19(2) Medication and Administration of all numbers that the physician including injectable (to be inject licensed practical nursident service). Duti supervisor. Every nursidealth service supervisor.	in these rules: nd treatment. a. nedications as ordered by g oral, instillations, topical, ed by a registered nurse or se only); (I, II)	I	\$4,00	0	Upon Receipt
	failed to properly admin physician orders for 1 or (Resident #311). On 3/2 Resident #311 another antipsychotic and an anown (a narcotic pain relibecame unresponsive, ambulance took her to to	29/19, Staff D administered resident's medication (an tidepressant) in addition to her iever). The result, the resident				

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Citation Number: 6978					Date: May 23,	2019
Facility Name: Rose Vista			Survey April 22	Dates: -25, 2019	9	
Facility Address/City/State/Zip 1109 Normal St. Woodbine, IA 51579						
,		JM				
Rule or Code Section	Nature of Violation			Fine A	Amount	Correction date
	residents. Findings include: According to the Minimulassessment tool dated 4 Brief Interview for Mental which indicated the resimpaired cognitive skills resident required extens mobility, transfers, ambigroom/corridor, toilet use remained independent valiagnoses that included Alzheimer's dementia, cand signs of accidental drug/meds/biological sulparts (MAR) directed second (MAR) directed second (MAR) directed second (MAR) contained States	4/19/19, Resident #311 had a all Status (BIMS) score of 8, dent displayed moderately. The MDS documented the sive assist of two staff for bedulation (walking) in and bathing. The resident with eating. The MDS listed Alzheimer's disease, non-depression, respiratory failure, poisoning by other				
	Resident #3's March 20 administer Seroquel 550 by mouth at bedtime. The	19 MAR directed staff to 0 mg and Trazodone 200 mg ne MAR contained Staff D's taff D gave the medication as				
		1's progress notes dated nined a late entry summary				Page 2 of 9

Facility Administrator Date

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Rule or Code Section	Nature of Violation			Fine Amount		Correction date
administer 100 mg, ar #311 anoth (antipsyche (antidepres revealed th the resider admitted to level positi The progre documente Seroquel a the emerge parameters transport F blood pres notes reve who slept v of breathin not rouse h information pulse, resp time of the A progress facility obta emergency called 911 the ER at 6	report of medication error. The note documented staff administered Resident #311 her scheduled Tramadol 100 mg, and then mistakenly administered Resident #311 another resident's (Resident #3) Seroquel (antipsychotic) 550 mg and Trazodone (antidepressant) 200 mg. The progress notes also revealed the critical access hospital (CAH) transferred the resident to a Level 3 Trauma Hospital where she admitted to ICU (intensive care unit) on a BIPAP (Bilevel positive airway pressure). The progress notes dated 3/29/19 at 10:50 PM documented the resident ingested Trazadone and Seroquel at approximately 8:15 PM. The nurse called the emergency room and the physician gave parameters to monitor vital signs every two hours and transport Resident #311 to the emergency room with blood pressure below 80/40 or pulse less than 40. The notes revealed at 9:00 PM, staff checked the resident who slept with periods of apnea (temporary cessation of breathing) per resident's usual, however, staff could not rouse her. The record failed to contain any information related to the resident's temperature, pulse, respirations, or blood pressure at or around the time of the medication error. A progress note dated 3/29/19 at 9:15 PM revealed the facility obtained an order to send Resident #311 to the emergency room for evaluation. At 9:17 PM, staff called 911 and resident transferred by ambulance to the ER at 9:30 PM.					Page 3 o

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Facility Administrator

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			Class	Fine A	Amount	Correction date
Section	the facility transferred the resident on 3/29/19 due to decreased breathing with periods of apnea and unresponsive episode after ingesting the wrong medications. The facility medication administration guidelines with an effective date of 6/1/07, directed staff to administer medications in accordance with written orders of the attending physician. The policy also directed staff to identify the residents receiving medications, and do not give medications supplied for one resident to another resident. In an interview with Staff D RN on 4/23/19 at 12:11 PM, she stated on 3/29/19 she set up 8:00 PM medications for both Resident #3 and Resident #311, entered Resident #311's room, and administered Resident #311 her 8:00 PM medications. Staff D RN reported she then became distracted while in Resident #311's room and subsequently administered Resident #3's 8:00 PM medications to Resident #311. She acknowledged she knew how medications were supposed to be given and also knew never to take two residents' medications with her at the same time. She reported as soon as she gave the medications to the resident she knew she gave them to the wrong resident, but Resident #311 cold not spit them out because she had already swallowed them. Staff D also she reported she called the Emergency Room within minutes and received an order to stay with the resident.					
		ctor of Nursing (DON) on	-	-		Page 4 of 5

Facility Advising the state of the state of

Facility Administrator

Date

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	A/25/19 at 7:33 AM stated she expected staff that passed medications to follow the 5 rights of medication administration (a nursing professional standard) and follow the facility medication administration policy. The DON stated staff should prepare one resident's medications, administer those medications, then move to a second resident to set up and pass medications without preparing two resident's medications at the same time. FACILITY RESPONSE:					

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Facility Administrator

Date