STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 000	INITIAL COMMENTS The Investigation of #90401-C was conducted 4/6/2020 - 5/4/2020. In addition to the Investigation, an Infection Control Survey was also conducted. As a result of the Investigation of #90401-C, an immediate jeopoard was determined and the facility was notified on 4/16/2020 at 8:45 a.m. The facility took appropriate action and the immediate jeopardy was removed on 4/22/2020 at 2:45 p.m. A condition-level deficiency was cited at W158. Standard-level deficiencies were cited at W192 and W368.	W 000	See attached POC 7/7/20	
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to ensure nursing staff demonstrated competent skills to ensure client health needs were met, specifically in regards to the administration and documentation of PRN (as needed) medications. Licensed Practical Nurse (LPN) A and Health Services Assistant (HSA) A failed to follow all facility policies/procedures and training regarding the administration of medications which lead to a serious medication error resulting a client being admitted to the hospital. This led to the determination of an Immediate Jeopardy. The facility was informed of the Immediate Jeopardy on 4/16/2020 at 8:45 a.m. The facility took immediate action by	W 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Chief Operating Officer | (X6) DATE: 7/8/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 158	Continued From page 1 updating the e-mar (electronic medication administration record) so all medication instructions were shown immediately without having to click on the medication name to obtain all pertinent instructions, including noting in the e-mar where the clients PRN seizure medication was stored. The facility nursing staff went through all medications and verified all PRN medications were available and stored in the correct location in the medication cupboard. Nursing staff continued weekly checks to ensure all PRN medications were available, and were stored in the designated location and/or a sign was posted where the medication was located. LPN A's employment with the facility was terminated, and the Director of Nursing and HSA A were demoted following the incident. HSA A later resigned her employment at the facility. All nursing staff, nurses and HSA's, were retrained to never borrow another client's medication, not to cancel an ambulance after called, the six rights of medication administration, the facility Medication Administration and ICF PRN Administration policy, and were retrained on the facilities two part medication administration training. The facility reviewed and revised all policies and procedures regarding medication administration, drug storage, labeling, and recordkeeping, and medication error reporting. The immediate jeopardy was removed on 4/22/2020 at 2:45 p.m. Cross references W192: Based on interviews and record review, the facility failed to ensure all nursing staff demonstrated competent skills with administering client PRN medications as evidenced by a Licensed Practical Nurse (LPN) and a Health Services Assistant (HSA) failure to follow all policies/procedures and training regarding the administration of PRN medications,	W 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 158	Continued From page 2 documentation of a medication error, and failure to document another client's PRN medication was used. Cross references W368: Based on interview and record review, the facility nursing staff failed to follow Physician Orders as written.	W 158		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure all nursing staff demonstrated competent skills with administering client PRN medications as evidenced by a Licensed Practical Nurse (LPN) and a Health Services Assistant (HSA) failure to follow all policies/procedures and training regarding the administration of PRN medications, documentation of a medication error, and failure to document another client's PRN medication was used. This affected 1 of 1 client (Client #1) involved in the investigation of 90401-C. Finding follows: Record review on 4/6/2020 revealed Client #1's nursing notes, dated 2/1/2020 - 4/6/2020. Review of the nursing notes revealed the following: a. On 2/6/2020, Licensed Practical Nurse (LPN) A documented staff reported to Health Services Assistant (HSA) A Client #1 was having a seizure, which lasted for 11 minutes. HSA A administered	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 3 10 milligrams (mg) diazepam per Client #1's order for seizures lasting longer than five minutes. After the seizure, LPN A noted Client #1 was acting his normal self. LPN A failed to document she instructed HSA A to use of another client's PRN medication after HSA A was unable to locate Client #1's PRN medication. b. On 2/7/2020, Registered Nurse (RN) A noted the ambulance was called and transported Client #1 to the hospital after it was reported the client was found to be weak, not able to stand well and was drowsy. It was then reported the client was given Ativan 10 mg by mouth last evening (2/6/2020) after possible seizure activity. RN A noted it was discussed in the Emergency Room (ER) that Client #1's weakness was related to the medication. Client #1 was admitted to the hospital to be observed. c. On 2/8/2020, RN B noted a late entry for 2/7/2020. RN B noted she was called to assess Client #1 after a fall from a bed. RN B documented weakness was noted and Client #1 was moved to the central area where he continued to try to get up but was unable to. Client #1 was falling over on a mat. RN B noted they decided to take Client #1 to the ER and called the ambulance to transport him due to the possible medication error the previous night and the client's behavior. When the paramedics arrived, they were given a report on the situation along with the possible medication, dosage, and amount Client #1 may have received. d. On 2/8/2020, RN B noted a late entry for 2/7/2020 at 6:30 p.m. RN B noted Client #1 was discharged from the hospital. He was admitted for observation for an accidental lorazepam	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 4 overdose and seizure activity. IV fluids were given. Seizure medication given prior to discharge. Resume medications and PRN's as before. Resume diet as before. Client needs to have assistance with ambulation until steady on his feed again. This could be 1-3 days. Continued record review on 4/9/2020 revealed the following: a. Client #1's Risk Management Plan, approved 7/23/19. The Risk Management Plan identified Client #1 was at high risk of seizures. The issues/barriers regarding the risk was due to physician diagnosis. The section titled "Plan to mitigate risk" noted "Monitor and record seizure activity for length, frequency, antecedents, and actions. Implement seizure precautions. Use protective devices if ordered. Remove harmful objects and keep Environment clear of obstructions. Assess and document client's motor and/or sensory deficit to determine safety needs." The intended outcome of the plan was to lower the risk. b. Client #1's Healthcare Plan (HCP) for seizures, last reviewed 7/23/19. The HCP instructed to monitor and record seizure activity for frequency, antecedents, and actions. Implement seizure precautions. Use protective devices if ordered. Remove harmful objects and keep environment clear of obstructions. Assess and document client's motor and/or sensory deficit to determine safety needs. Administer seizure medications as ordered. Assess and document effectiveness of medications. Confer with physician. c. Medication Error Report, dated 2/7/2020. According to the report, on 2/6/2020 at 8:32 p.m.	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 5 Client #1 was given lorazepam intensol liquid in place of diazepam Diastat rectal medication. According to the report, the error was discovered the following morning because Client #1 was very lethargic and uncoordinated. Staff that worked the night before reported Client #1was given another clients PRN (as needed) medication for seizures orally. The medication given was too high of a dose causing an overdose. Client #1 was transferred to the ER and monitored until that evening. d. An Investigation Report, initiated 2/7/2020 after Client #1 was taken by ambulance to the hospital due to not being fully alert and not able to stand on his own. The report noted Client #1 had an 11-minute seizure around 8:30 p.m. on 2/6/2020 and a PRN was given, noting he could have received the wrong medication. According to the internal investigation, Residential Supervisor 2 (RS2) A reported she worked during the second shift on 2/6/2020 and had witnessed Client #1 receive another client's medication following his seizure. The facility concluded Client #1 had received lorazepam instead of diazepam. The facility interviewed HSA A and LPN A. HSA A reported she gave Client #1 10 mg of the other client's seizure PRN medication; LPN A stated HSA A gave Client #1 10 mg of diazepam. The investigation noted the other client's medication was lorazepam and concluded Client #1 was given 10 mg of lorazepam instead of 10 mg of diazepam. The facility determined there was a breakdown of communication between HSA A who administered the medication and LPN A who approved the PRN; noting LPN A made the dosage conversion but was under the impression HAS A was giving diazepam.	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 6 e. Continued record review revealed Client #1's 90-Day Physician Orders, signed 1/31/2020. The orders instructed for seizures last greater than five minutes, or clusters of seizures equaling five minutes, Client #1 was to receive diazepam (Diastat Acudial) 10 mg rectally. f. Review of Client #1's Medication Administration Record (MAR) revealed on 2/6/2020 at 8:32 p.m. HSA A documented "Diazepam: had a seizure over 5 mins Followup result: PRN was effective. Followup comment: ok at this time. Comment: Followup administered". When interviewed on 4/9/2020 at 1:40 p.m., Nurse Coordinator (NC) A reported she assisted with part of the internal investigation when interviewing LPN A and HSA A. NC A stated, from her understanding, on 2/6/2020 Client #1's PRN seizure medication could not be located. She stated it was on a different shelf than it was normally stored and said they were looking for an oral medication, not a rectal medication. She stated most of the client PRN medications were oral but a couple clients had prescriptions to receive medications rectally. NC A stated Client #1's PRN diazepam was there but it was on the third (top) shelf in the medication cabinet. NC A said on the e-mar, after identifying seizure, diazepam PRN showed. She explained to get the rest of the instructions staff would click on the medication name and it showed to give the diazepam rectally. NC A confirmed Client #1's HCP appeared basic. She explained she was developing a new form that would list the seizure type and symptoms, what medication the client took for seizures, and any PRN medications. NC A stated it was not common practice to borrow another client's PRN medication. NC A reported	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 7 if an ambulance was called then the paramedics should come, assess the client, and if the paramedics did not think the client needed to go to the hospital they would make the decision, not the nurse. NC A reported the Daisy Lane House was not HSA A's primary house to work; it was her second house. She stated they try to have all HSA's work in their second house off and on to keep familiarity of the second house. NC A explained LPN A worked at the facility, as needed, and normally did not work in the Daisy Lane House but said nurses assisted, as needed, in all four of the facility houses. When interviewed on 4/9/2020 at 2:20 p.m., Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) A stated, prior to this incident, on a rare occasion they would borrow PRN medications, but only medications that could be purchased over-the-counter like Tylenol or Miralax. She stated she would never borrow a PRN medication if it could not be purchased over-the-counter, even if a client's PRN medication could not be located. She stated if an ambulance was called it should not be canceled. She said the paramedics should come out and make the decision if the client needed to go to the hospital. When interviewed on 4/13/2020 at 9:05 a.m., LPN A said she was the first nurse on-call on 2/6/2020. LPN A explained she was working in the Oakridge House when she received a call from HSA A who was working in the Daisy Lane House, the house Client #1 resided in. LPN A said HSA A reported Client #1 was having a seizure, which was going on five minutes, and Client #1 had a diazepam PRN medication and requested permission to administer the PRN. LPN A	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 8 explained she looked up Client #1's seizure medication on the e-mar (electronic Medication Administration Record); the e-mar instructed Client #1 was to receive 10 mg of diazepam for seizures lasting longer than five minutes. LPN A explained HSA A called back again and stated she could not find Client #1's PRN medication. LPN A said she instructed HSA A to see if any other client had the same PRN medication to borrow for Client #1. LPN A stated she knew this was not good practice, but it was a common practice, when unable to locate a client's PRN medication. LPN A stated she instructed HSA A to find another client's diazepam, so when HSA A called and read her the dose she provided HSA A with the dosage conversion, which was to give 5 cc's to equal the 10 mg dose. LPN A stated she never heard HSA A say lorazepam and explained the phone call had dropped (disconnected) two times while HSA A was looking for the medication. LPN A said HSA A called again when Client #1 had been in a seizure for approximately ten minutes so she instructed to call the ambulance. LPN A stated when she was on her way to the Daisy Lane House, HSA A called back and told her Client #1 had stopped seizing; LPN A told HSA A to cancel the ambulance and stated she was on her way to Daisy Lane. LPN A said when she got to the house, HSA A had the medication in a medication cup and was preparing to give it to Client #1. She said Client #1 took the PRN medication and then had a behavior. HSA A handed her the medication boxes but she never looked at them, she just put them away while HSA A was assisting with Client #1's behavior. LPN A said afterwards, they found Client #1's diazepam PRN on the top shelf in the opposite cupboard from where the PRN medications were normally stored. She stated after the medication	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 9 was located, she found out it was to be given rectally. LPN A explained when she looked up the medication in the e-mar she did not see it was to be given rectally and did not know to click on the medication name to obtain additional information since she had not been trained on the e-mar system. LPN A confirmed they should have completed a Medication Error Report because he received the medication by the wrong route, orally not rectally, but said she did not think about it since he took his other medications orally. When interviewed on 4/13/2020 at 12:25 p.m., HSA A stated on 2/6/2020 she was the HSA at the Daisy Lane House. HSA A said after 8:00 p.m., Client Support Staff (CSS) A told her he thought Client #1 was having a seizure. HSA A reported she went and checked on Client #1, his eyes were darting back and forth, and he was not responding. HSA A said she checked the e-mar and Client #1 had a PRN for diazepam 10 mg for seizures. HSA A said she called LPN A, who had the nurse on-call phone, and told her Client #1 was having a seizure, it had been almost five minutes, and asked if she could administer his PRN seizure medication. She stated LPN A reviewed the e-mar and gave permission to give Client #1 his PRN diazepam. HSA A explained she was not able to find Client #1's PRN medication and LPN A told her to look to see if any other client had diazepam they could borrow for Client #1. HSA A said she found diazepam but the dose was higher than what Client #1 was to receive. HSA A said she found another client had lorazepam and told LPN A what she found. HSA A explained she had a speech impediment and while she talked to LPN A the phone was cutting out, dropped the call two times, and she finally called LPN A on her personal cellular phone. HSA	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 10 A said, looking back, she was not sure if LPN A heard her or if LPN A understood her correctly when she told LPN A she found lorazepam. HSA A reported LPN A gave her the conversion for the amount to give for the correct dose. HSA A explained when Client #1 had been seizing for 10 minutes, LPN A instructed her to call the ambulance but then told her to cancel the ambulance after Client #1's seizure stopped at 11 minutes. HSA A said LPN A arrived at the house when she was going to give Client #1 the medication. HSA A reported Client #1 had a behavior, she assisted with it, and afterwards, she and LPN A searched the medication cupboards for Client #1's PRN. HSA A said they finally found the medication on the top shelf, pushed back some in the medication cupboard. HSA A reported this was when they discovered the medication was to be given rectally. She said LPN A told her it would be okay since he received the right dose, and he took all his other medications orally. HSA A stated when she had checked the e-mar it only showed the medication name and dose, not that he was to receive it rectally. The following day, she stated someone had changed the e-mar to reflect the medication was to be given rectally. HSA A said she knew she should not borrow another client's PRN medication but said it happened at the facility. She explained at the time, she was worried about Client #1 and wanted to get him his medication because it was uncommon for his seizures to last that long and knew he needed his PRN medication. HSA A said she did not know lorazepam and diazepam were different medications. She explained when LPN A gave permission to use the lorazepam she figured they were the same medication since she knew a medication may be the same but have different	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 11 names. HSA A stated she did not document she used another client's PRN medication because LPN A was present and aware. HSA A explained she became a HSA, which was a Certified Medication Aide, approximately one year ago. She stated she was an HSA in the Evergreen House and was trained in the Oakridge House. HSA A explained she then started to assist, as needed, in the Daisy Lane House and was trained by another HSA. HSA A explained when she was trained by the HSA, there was not a training sheet to use to go over the specifics of the house. She said she was not shown where Client #1's PRN medication was stored and explained each house had a different set-up for where the PRN medications were stored. When interviewed on 4/14/2020 at 11:50 a.m., the Director of Nursing (DON) confirmed a Medication Error Report should have been completed for Client #1 after LPN A and HSA A found his PRN and realized it was given orally instead of rectally. The DON said the bigger concern was he received the wrong medication; a Medication Error Report was completed after the error was discovered on 2/7/2020. The DON stated LPN A should have told HSA A to wait for her to arrive at the house before she gave the medication especially since they were having phone issues. She said after HSA A handed LPN A the medication boxes, LPN A should have looked at them to ensure the correct medication was given before putting it away. The DON explained anytime a HSA and/or nurse had a question about a medication they should look it up to ensure it was correct; she stated this was part of the training. She stated all HAS's and nurses were to follow the six rights of medication administration, which were the right person, right	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 12 medication, right dose, right route, right time, and right documentation. Additional record review on 4/15/2020 - 4/16/2020 revealed the Medication Administration Lesson 1 training, undated. The training instructed someone else's medication, even if it is the same drug, was not be used, noting each client would have their own bottle or unit dosage. The training instructed to remember and follow the six rights of medication administration the right client, right medication, right dose, right time, right route, and right recording with each medication administration. The training identified different medication errors, which included the incorrect route was used. The training instructed for all medication errors, the nurse on-call was to be notified, a Medication Error Report was to be completed, and the error was to be documented in the client's electronic documentation. Continued review revealed the Medication Administration Lesson 2 training, undated. The training provided instruction how to access PRN medication in the e-mar system. The training provided step-by-step instructions, which included to click on the medication name to obtain instructions. This led to the determination of an Immediate Jeopardy. The facility was notified of the Immediate Jeopardy on 4/16/2020 at 8:45 a.m. The Assistant Executive Director (AED) confirmed LPN A and HSA A made numerous mistakes on 2/6/2020. She said LPN A should not have instructed HSA A to borrow another client's medication; HSA A should have looked up the medication to ensure they were the same. She confirmed LPN A should have told HSA A not to	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 192	Continued From page 13 give the medication until she was able to look at it since they were having phone issues. The AED confirmed there was no documentation another clients medication was given to Client #1. She confirmed LPN A and HSA A failed to complete a Medication Error Report after they realized Client #1 was to receive his medication rectally and the medication was administered orally. The AED stated after the ambulance was called, it should have never been canceled. She explained if the paramedics did not feel Client #1 needed to be transported to the hospital, they should have made the decision after they assessed Client #1 instead of the ambulance being canceled. The AED stated after the medication error was discovered on 2/7/2020, the facility retrained all nursing staff and HSA's on the Medication Administration Policy, the ICF PRN Administration Policy, never to borrow another client's medications, never to cancel an ambulance, and the six rights of medication administration. She stated the facility changed the e-mar so all medication instructions showed immediately without having to click on the medication name, including noting on the e-mar where Client #1's PRN diazepam was stored. The nursing staff went through all medication cupboards to ensure all PRN medications were present and in the correct location. Nursing staff continued weekly checks of all medications, including the PRN medications, to ensure all medications were available and were stored in the designated location and/or a sign was posted where the medication was located.	W 192		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 14 that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility nursing staff failed to follow Physician Orders as written. This affected 1 of 1 client (Client #1) involved in the investigation of #90401-C. Finding follows: Record review on 4/9/2020 revealed a Medication Error Report, dated 2/7/2020. According to the report, on 2/6/2020 at 8:32 p.m. Client #1 was given lorazepam intensol liquid in place of diazepam Diastat rectal medication. The error was discovered the following morning after Client #1 was observed to be very lethargic and uncoordinated. Staff who worked the night before reported he had been given another clients PRN (as needed) medication for seizures orally. The medication given was too high of a dose causing an overdose. Client #1 was transferred to the ER (Emergency room), given IV fluids, and monitored until that evening. Additional record review revealed an Investigation Report, initiated 2/7/2020 after Client #1 was taken by ambulance to the hospital due to not being fully alert and not able to stand on his own. The report noted Client #1 had an 11-minute seizure around 8:30 p.m. on 2/6/2020 and a PRN was given, noting he could have received the wrong medication. According to the internal investigation, Residential Supervisor 2 (RS2) A reported she worked during the second shift on 2/6/2020 and had witnessed Client #1 receive another client's medication following his seizure. The facility concluded Client #1 had received	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 15 lorazepam instead of diazepam. The facility interviewed Health Services Assistant (HSA) A and Licensed Practical Nurse (LPN) A. HSA A reported she gave Client #1 10 mg of the other client's seizure PRN medication; LPN A stated HSA A gave Client #1 10 mg of diazepam. The investigation noted the other client's medication was lorazepam and concluded Client #1 was given 10 mg of lorazepam instead of 10 mg of diazepam. The facility determined there was a breakdown of communication between HSA A who administered the medication and LPN A who approved the PRN; noting LPN A made the dosage conversion but was under the impression HSA A was giving diazepam. Continued record review revealed Client #1's 90-Day Physician Orders, signed 1/31/2020. The orders instructed for seizures last greater than five minutes, or clusters of seizures equaling five minutes, Client #1 was to receive Diazepam (Diastat Acudial) 10 mg rectally. Review of Client #1's Medication Administration Record (MAR) revealed on 2/6/2020 at 8:32 p.m. HSA A documented "Diazepam: had a seizure over 5 mins Followup result: PRN was effective. Followup comment: ok at this time. Comment: Followup administered". When interviewed on 4/13/2020 at 9:05 a.m., LPN A said she was the first nurse on-call on 2/6/2020. LPN A explained she was working in the Oakridge House when she received a call from HSA A who was working in the Daisy Lane House, the house Client #1 resided in. LPN A said HSA A reported Client #1 was having a seizure, which was going on five minutes, and Client #1 had a diazepam PRN medication he was to	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 16 receive and requested permission. LPN A explained she looked up Client #1's seizure medication on the e-mar (electronic Medication Administration Record); which instructed Client #1 was to receive 10 mg of diazepam for seizures lasting longer than five minutes. LPN A explained HSA A called back again and stated she could not find Client #1's PRN medication. LPN A said she instructed HSA A to see if any other client had the same PRN medication, to borrow for Client #1. LPN A stated she knew this was not good practice, but it was a common practice, when unable to locate a client's PRN medication. LPN A stated she instructed HSA A to find another client's diazepam, so when HSA A called and read her the dose she provided HSA A with the conversion, which was to give 5 cc's to equal the 10 mg dose. LPN A stated she never heard HSA A say she found lorazepam and explained the phone call had dropped (disconnected) two times while HSA A was looking for the medication. LPN A said HSA A called again when Client #1 had been in a seizure for approximately ten minutes so she instructed to call the ambulance. LPN A stated when she was on her way to the Daisy Lane House, HSA A called back and told her Client #1 had stopped seizing; LPN A told HSA A to cancel the ambulance and said she was on her way to Daisy Lane. LPN A said when she got to the house, HSA A had the medication in a medication cup and was preparing to give it to Client #1. She said Client #1 took the PRN medication and then had a behavior. HSA A handed her the medication boxes but she never looked at them, she just put them away while HSA A was assisting with Client #1's behavior. LPN A said afterwards, they found Client #1's diazepam PRN on the top shelf in the opposite cupboard from where the PRN medications were	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 17 normally stored. She stated after the medication was located, she found out it was to be given rectally. LPN A explained when she looked up the medication in the e-mar she did not see it was to be given rectally and did not know to click on the medication name to obtain additional information since she had not been trained on the e-mar system. LPN A confirmed they should have completed a Medication Error Report because he received the medication by the wrong route, orally not rectally, but said she did not think about it since he took his other medications orally. LPN A stated again, she did not know Client #1 received lorazepam since HSA A was looking for diazepam, which was what she thought she was giving the conversion for. When interviewed on 4/13/2020 at 12:25 p.m., HSA A stated on 2/6/2020 she was the HSA at the Daisy Lane House. HSA A said after 8:00 p.m., Client Support Staff (CSS) A told her he thought Client #1 was having a seizure. HSA A reported she went and checked on Client #1, his eyes were darting back and forth, and he was not responding. HSA A said she checked the e-mar and Client #1 had a PRN for diazepam 10 mg for seizures but the e-mar did not instruct to give the medication rectally. HSA A said she called LPN A, who had the nurse on-call phone, and told her Client #1 was having a seizure, it had been almost five minutes, and asked if she could administer his PRN seizure medication. She stated LPN A reviewed the e-mar and gave permission to give Client #1 his PRN diazepam. HSA A explained she was not able to find Client #1's PRN medication and LPN A told her to look to see if any other client had diazepam to borrow for Client #1. HSA A said she found diazepam but the dose was higher than what Client #1 was to	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 18	W 368		

receive. HSA A said she found another client had lorazepam and told LPN A what she found. HSA A explained she has a speech impediment and while she was talking to LPN A the phone was cutting out, dropped the call two times, and she finally called LPN A on her personal cellular phone. HSA A said, looking back, she is not sure if LPN A heard her or if LPN A understood her correctly when she told LPN A she found lorazepam. HSA A reported LPN A gave her the conversion for the amount to give for the correct dose. HSA A explained when Client #1 had been seizing for 10 minutes, LPN A instructed her to call the ambulance but then told her to cancel the ambulance when Client #1's seizure stopped at 11 minutes. HSA A said LPN A arrived at the house when she was going to give Client #1 the medication. HSA A reported Client #1 had a behavior, she assisted with it, and afterwards, she and LPN A searched the medication cupboards for Client #1's PRN. HSA A said they finally found the medication on the top shelf, pushed back some in the medication cupboard. HSA A reported this was when they discovered the medication was to be given rectally. She said LPN A told her it would be okay since he received the right dose, and he took all his other medications orally. HSA A stated when she had checked the e-mar it only showed the medication name and dose, not that he was to receive it rectally. HSA A said she knew she should not borrow another client's PRN medication but said it happened at the facility. She explained at the time, she was worried about Client #1 and wanted to get him his medication because it was uncommon for his seizures to last that long and knew he needed his PRN medication. HSA A said she did not know lorazepam and diazepam were different medications. She explained when LPN A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 19 gave permission to use the lorazepam she figured they were the same medication since she knew a medication may be the same but have different names. HSA A stated she did not document she used another client's PRN medication because LPN A was present and aware. Review of facility policies revealed the "Medication Error Policy", last revised 11/24/17. The policy instructed medication errors would be reported to the 1st Nurse on call, appropriate documentation and follow-up would be completed. The policy defined medications given by the wrong route and/or the wrong medication given were considered an error. When interviewed on 4/14/2020 at 11:50 a.m., the Director of Nursing (DON) confirmed a Medication Error Report should have been completed for Client #1 after LPN A and HSA A found his PRN and realized it was given by the wrong route, orally instead of rectally. The DON confirmed Client #1 received the wrong medication PRN seizure medication; a Medication Error Report was completed after the error was discovered. The DON stated LPN A should have told HSA A to wait for her to arrive at the facility to give the medication especially since they were having phone issues. She said after HSA A handed LPN A the medication boxes, LPN A should have looked at them to verify what medication was given before putting it away. When interviewed by e-mail on 4/15/2020 at 2:59 p.m., the Director of Quality Assurance and Staff Training (DQAST) explained anyone who assisted with medication administration were taught to follow the six rights of medication	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 05/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 368	Continued From page 20 administration, which included the right medication. She confirmed HSA A failed to follow the six rights of medication administration and it resulted in a serious medication error on 2/6/2020. When interviewed on 4/16/2020 at 8:45, the Assistant Executive Director (AED) confirmed LPN A and HSA A made numerous mistakes on 2/6/2020. She said LPN A should not have instructed HSA A to borrow another client's medication and HSA A should have looked up the medication to ensure they were the same. She confirmed LPN A should have told HAS A not to give the medication until she was able to look at it since they were having phone issues. The AED confirmed there was no documentation another clients medication was given to Client #1 and LPN A and HSA A failed to complete a Medication Error Report after they realized Client #1 was to receive his medication rectally and the medication was administered orally.	W 368		

OK
7/14/20

New Hope Village
Plan of Correction
DIA Investigation #90401-C
4/6/20 – 5/4/20

Summary

The Department of Inspection and Appeals conducted an Investigation into incident #90401-C at New Hope from April 6 to May 4, 2020. In addition to this investigation, an Infection Control Survey was conducted in which no deficiencies were cited.
Investigation #90401-C was identified on ~~4/16/20~~ as an Immediate Jeopardy to clients' health and safety. The IJ was removed on 4/22/20.

The incident investigated occurred on 2/6/20 resulted in a client being given another client's PRN medication which was the incorrect medication, this error resulted in the person having to go to the emergency room due to being very unsteady and it was discovered not only was the client given the wrong medication but the amount given was considered an accidental overdose. The client was admitted to the hospital for observation and was discharged the same day.

The following actions had been completed by the agency prior to the investigation:

1. The incident was reported to Department of Inspections and Appeals on 2/7/20 and an immediate investigation was completed.
2. The HSA and LPN involved in the incident were suspended pending the outcome of the investigation on 2/7/20.
3. Health Services staff were re-trained on the following topics: (This training was initiated on 2/10/20)
    a. All administration of medications will follow the 6 rights of Medication Administration.
    b. Absolutely no client is to receive another client's medication.
    c. Ensuring all medication cupboards are clearly labeled with where the PRN medications are located.
    d. Do not cancel an ambulance once you have called 911
    e. Reviewed the Drug Administration policy and ICF PRN policy
4. All Nurse Coordinators were instructed to double check all the medication areas for their home to make sure that there was an adequate supply of PRN medications, order what was needed and ensure the location of PRNs was properly labeled. In addition, staff were instructed to check PRN medications on Mondays and Thursdays to ensure there is an adequate supply at all times. These checks are documented through the eMAR system.
5. During the monthly health services meeting on 2/26/20, the following was discussed about Medication Administration:
   Medication Administration- Remember follow the 6 Rights with EVERY MED PASS!
    a. The practice of sharing medications is prohibited, including PRNs!
    b. Please make sure that when you are completing the medication switchover that you check all the PRNs for each person.
        i. If the PRN has expired, put the cassette in the box with the cassettes that are leaving the house and call the pharmacy to order the needed PRN.
        ii. If you are administering a PRN and the person is almost out, call the pharmacy and order the PRN the person will need.
        iii. PRNs in ICF should also be checked on Thursday night to make sure we have enough to get through the weekend.
6. New Hope's policy on 'Administration of PRN Medication in ICF/ID Staff by the Health Services Assistants/Certified Medication Aides' was revised.
7. The PRN section of the eMAR was modified for individuals with PRN Seizure Medications to ensure that the dose and route was listed with the medication so that you didn't have to 'click the radio' button to see the dose and route. In addition, we added where the PRN medication was stored so people wouldn't have to look for it further.
8. The HSA was demoted to a position that did not have responsibility for administering medications.
9. The LPN who gave approval for the administration of the PRN was permitted to resign in lieu of termination.
10. The Director of Health Services was demoted for failing to ensure staff were appropriately trained.

New Hope Village
Plan of Correction
DIA Investigation #90401-C
4/6/20 – 5/4/20

DIA's findings of this investigation are as follows:

W158 Facility Staffing-Condition-level deficiency
W192 Staff Training Program-Standard-level deficiency
W368 Drug Administration-Standard-level deficiency

The following Plan of Correction has been developed to correct these deficiencies.

Tag #	Deficiency Cited	Plan of Correction/Compliance monitoring	Person(s) Responsible	Target Date for Completion	Status
W158	The facility failed to ensure nursing staff demonstrated competent skills to ensure client health needs were met, specifically regarding the administration and documentation of PRN (as needed) medications.	Action Plan: 1. The Director of Nursing (DON) completed a compliance check to ensure all PRN medications are stored appropriately and the cupboards are clearly labeled.	Kelley Mead, DON	4/16/20	Completed 4/16/20
		2. The DON sent a memo to all health services staff about ensuring all PRN medications are in a central location in each home and reminding them about the weekly checks of PRNs on Mondays and Thursdays.	Kelley Mead, DON	4/16/20	Completed 4/16/20
		3. The DON verified that the Monday and Thursday checks of PRN medication are listed on eMar.	Kelley Mead, DON	4/16/20	Completed 4/16/20
		4. The DON completed a compliance check of the eMAR to ensure all PRN medications for seizures include the dose, route and location of PRN with the medication without additional navigation in the eMAR system.	Kelley Mead, DON	4/16/20	Completed 4/16/20
		5. The DON verified that all current Health Services Staff have received the Medication	Kelley Mead, DON	4/16/20	Completed 4/16/20

		Administration re-training that was initiated on 2/10/20.			
		6. The Director of Quality Assurance and Staff Training will complete an audit of the training for Health Services Staff to ensure all of them have completed the New Hope 2-Part Medication Administration training.	Lacie Tedrow, DoQA&ST	4/17/20	Completed 4/17/20
		7. The DON will review the following policies related to Drug Administration and revise if needed: • Drug Administration • Medication Administration Requirements • Administration of PRN Medications in ICF/ID Staff by Medication Aides • Certified Medication Aides Delegated to Administer Medications through a G/J Tube in ICF/ID • Medication Error Policy	Kelley Mead, DON	4/20/20	Completed 4/20/20
		8. Health Services staff were trained on the revised policies.	Kelley Mead, DON	5/15/20	Completed 5/7/2-
		9. The Consultant Pharmacist will review the following policies related to Drug Administration and the DON will revise per the Consultant Pharmacist recommendations: • Drug Storage, Labeling, and Recordkeeping • Controlled Drugs- ICF/ID and HCBS Services • Pharmacy Services	Kelley Mead, DON	7/15/20	Completed 7/7/20

		Compliance monitoring: 1. Health Services staff perform twice weekly compliance checks to ensure all PRN medications are stored appropriately and cupboards are clearly labeled. These checks are notated on the eMAR which is monitored by the Nurse Coordinators. 2. Nurse Coordinators will ensure that all current and newly added PRN seizure medications include the dose, route and location of PRN with the medication without additional navigation in the eMAR system. 3. Training is conducted through the e-learning system and is monitored by the Training Department to ensure all training is completed. 4. All new Health Services staff are trained on all relevant medication policies.	Kelley Mead, DON Nurse Coordinators Kelley Mead, DON Jean Young, Ass't DON and Nurse Coordinators Jean Young, Ass't DON	In effect In effect In effect In effect	On-going On-going On-going On-going
W192	The facility failed to ensure all nursing staff demonstrated competent skills with administering client PRN medications.	Action Plan: 1. Refer to Plan of Correction for W158. Compliance monitoring: 1. Refer to Plan of Correction for W158.			

New Hope Village
Plan of Correction
DIA Investigation #90401-C
4/6/20 – 5/4/20

W368	The facility nursing staff failed to follow Physician Orders as written.	**Action Plan:** 1. Refer to Plan of Correction for W158. **Compliance monitoring:** 1. Refer to Plan of Correction for W158.			

Kelley Mead DON
Kelley Mead, Dir. Of Nursing

7-8-2020
Date

Kim Platt DON
Kim Platt, Dir. Of Residential Services

7-8-2020
Date

LeAn Taylor, COO
LeAn Taylor, Chief Operations Officer

7/8/20
Date