

OK 2/16/17 *CAC 3/16/17*

PRINTED: 02/23/2017
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/21/2017
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

BETHANY HEIGHTS 11 ELLIOTT STREET
CO BLUFFS, IA 51503

(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	481-67 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. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 38 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 54 TOTAL census of Assisted Living Program: 54 The following regulatory insufficiencies were cited during the investigation of Incident #63820-I:	A 000	1. Tenant #1 no longer resides at Bethany Heights Senior living. 2. All Program medication staff reviewed all policies and procedures related to med pass. Staff A and Staff B re-delegated to safe med pass. Staff A spent a total of 8 hours 1:1 with RN or designee for med pass observation. Staff B spent a total of 8 hours 1:1 with RN or designee for med pass observation. 3. All med pass staff will be monitored for compliance with policies and procedures during med pass no less than annually. 4. The plan of correction will be in effect as of March 23, 2017.	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interviews and record review Program staff failed to follow the Program's policy for medication administration. As a result, a tenant received another tenant's medications. The	A 003		

POC 3/23/17

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Maude Fendry

Housing Director

3-2-2017

STATE FORM

6889

Z9VV/11

If continuation sheet 1 of 4

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A 003	<p>Continued From page 1</p> <p>tenant experienced complications and required hospitalization. This affected 1 of 1 tenant reviewed as a result of Incident 63280-1 (Tenant #1). Finding follows:</p> <p>Record review on 1/23/17 revealed a progress note for Tenant #1, dated 10/9/16 at 12:01 p.m. which documented, "Notified by (Staff A) and (Staff B) at 9:15 a.m. tenant was given another tenants medications by mistake. Staff reported the error occurred around 8:00 a.m. and noticed staff at 9:15 a.m. ADON (Assistant Director of Nursing) notified at 9:20 a.m. Medications were: Amlodipine 10 mg, Acetaminophen 1000 mg, Hydrochlorothiazide 12.5 mg, Metoprolol 50 mg, Multivitamin, Valsartan 320 mg. This nurse advised staff not to give tenant routine medications, and asked for staff to get vitals. VS (vital signs) 98.4-54-20-138/76-89% on room air. On call MD (Medical Doctor) was called at 9:30 am, (MD) returned call at 9:45 am and order BP (blood pressure) and P (pulse) every half hour for 3 hours, call back if BP drops below 100/60 or P drops below 60. Staff checked VS at 9:45 am BP noted to be 130/56, and radial pulse 48. This nurse assessed tenant, apical pulse 57 and very irregular. Attempted to reach on call MD at that time, VS checked at 10:15 am BP noted to be 102/62 and radial pulse 48. On call MD called again, returned call at 10:40 am and requested tenant be seen in the ER (Emergency Room). BP and pulse [at] 106/52 and 54 bpm..."</p> <p>Further review of Tenant #1's progress notes revealed documentation from 10/9/16 at 2:01 p.m., which noted, "... Tenant being admitted for low heart rate... tenant's heart rate has been down in the 30s and blood pressure has been elevated..." A progress noted documented 10/10/16 at 3:01 p.m. noted, "... Tenant returned</p>	A 003		

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A 003	<p>Continued From page 2</p> <p>to ALF (assisted living facility) today..."</p> <p>Additional record review revealed Tenant #1's summary of hospitalization from CHI Mercy indicated admission to the hospital on 10/9/16 and discharge on 10/10/16. Reason for hospitalization was listed as slow heart rate.</p> <p>Tenant #1, admitted to the Program on 8/24/16, had diagnoses including, but not limited to: hypothyroidism, type 2 diabetes mellitus without complications, hyperlipidemia, essential hypertension, arterosclerotic heart disease of native coronary artery with unspecified angina pectoris, chronic kidney disease stage three, edema, and personal history of transient ischemic attack. Tenant #1 had</p> <p>Record review on 1/23/17 revealed the Program's Policy entitled Medication Administration by Facility Staff effective 5/1/08. According to the policy staff should remember to check the five rights of medication administration which included; right tenant, right drug, right dose, right time and right route. Including in the policy was the following under "DO NOTS" of medication administration. "DO NOT give drugs you have not set up" and "DO NOT give if not positive of tenant identification."</p> <p>When interviewed on 1/23/17 at 3:05 p.m. Staff A admitted/confirmed she failed to follow policy when she set up the medications and handed them to Staff B to give to a tenant. Staff B administered the medications to the wrong tenant.</p> <p>When interviewed on 1/23/17 at 10:35 a.m. Staff B confirmed she administered medications to the wrong tenant after Staff A set up the medications</p>	A 003		

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A 003	Continued From page 3 and handed them to her. When interviewed on 1/23/17 at the Director of Nursing (DON) confirmed both Staff A and B admitted they failed to follow policy when Tenant #1 received Tenant #2's medication by mistake. She said Tenant #1 returned to the Program after the hospitalization before requiring a higher level of care.	A 003			