DEPARTMENT OF INSPECTIONS AND APPEALS

4/22/19 OK

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0368	A. BUILDING: _____ B. WING _____	C 12/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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	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. General Population program: Number of tenants without cognitive disorder: 14 Number of tenants with cognitive disorder: 1 Total population of Program at time of on-site: 15 Dementia-Specific Program by Dedication: Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 10 Total population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 25 The following regulatory insufficiency was cited during the investigation of Complaint #79828: 67.5 (6) d.	A 000	See attached POC 12/12/18	
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the Program failed to administer tenants' medications as prescribed by a physician. This affected 1 of 3 tenants reviewed during the investigation of	A 147		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 147	Continued From page 1 #79828-C. Finding follows: Record review on 12/11/18 revealed a program medication error record, dated 9/3/18, documented staff went to administer morning medications to Tenant #1 on 9/3/18 and found another tenant's medications in her medication cabinet, including two bubble packs containing Vitamin D3 and Donepezil (Aricept). The medications were not prescribed to Tenant #1. The bubble packs were opened on 8/31/18. The Nurse was notified and the Nurse notified the family and physician of the error. The report further noted Tenant #1 was sent to the ER on Friday, 8/31/18 with complaints of nausea, vomiting, diarrhea, elevated BP and a sweaty/clammy feeling. The report noted no injuries observed post incident. Further review of the record documented, "medications were placed in the wrong resident's apartment and were administered to the wrong resident." A Program Progress note, dated 9/4/18, documented an order received to push fluids and Ondansetron (anti-nausea/vomiting medication) was ordered as needed for nausea. Further record review on 12/11/18 revealed a Counseling Documentation Form, dated 9/5/18, for Staff B, noted on 8/31/18, 9/1/18 and 9/2/18 staff administered two incorrect medications to Tenant #1. The form noted, "This caused the resident to become very ill." The form stated the action was a written warning and the nature of the violation was a policy or safety violation. According to the Medication Administration policy, staff should go to resident's apartment, unlock cabinet and administer appropriate medications.	A 147		

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A 147	Continued From page 2 Once meds were administered staff should sign the MAR prior to locking cabinet again. When interviewed on 12/11/18, the Healthcare Coordinator (HC) confirmed Tenant #1 received the wrong medications on 8/31/18, 9/1/18 and 9/2/18. She added the wrong bubble packs were placed in Tenant #1's cabinet. She noted the Tenant went to the ER for nausea on 8/31/18. The tenant was prescribed Ondansetron and returned to the Program after "an hour or so." The HC added the nausea may or may not have been related to Tenant #1 receiving the wrong medications. The HC stated she was not sure how staff member B could have made the medication error, as all medications administered by staff were done electronically. During additional interview on 12/11/18, the HC described how Tenants' medications were delivered from the pharmacy. She noted the evening staff responsible for mediations checked in the medications and placed the medications in the tenants' apartment cabinets. When asked if there was a program policy regarding medication delivery from the pharmacy, the HC reported there was no policy, but the program was in the process of creating a policy for medication delivery from pharmacy. The HC also reported the Program no longer administered the Tenant's medications, as the family had currently taken over that responsibility.	A 147		

1/22/19

Edencrest at Siena Hills
455 SW Ankeny Rd, Ankeny IA 50023

Date: 1/22/2019

Complaint Intake #: 79828-C

Plan of Correction (POC) Submitted For:
- Investigation Date: 12/11/18

POC:

A. ***Regulatory Insufficiency:***

A 147 481-67.5(6)d Medications
481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following:
67.5(6) When medications are administered traditionally by the program:
d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**: The two staff involved a written warning and were mandated to take the medication management class again and were re-med delegated. All staff re-educated on medication administration and how to report to nursing if medications are not available. We now have two staff verify all medications before they are delivered to apartments.

2. **Actions the program is taking to protect tenants in similar situations**: All meds are now hole punched and put together on a ring per each medication pass for each resident. Will continue to educate staff on med management and delegate. We will continue to have two staff verify medications before delivering to residents apartments.

3. **Measures taken to ensure problem does not recur:** All staff are educated upon hire and when med delegated. Nurse monitors MAR

reports frequently, at least monthly to ensure meds are properly administered and documented.

Date of compliance was 12/12/18

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.