STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165033	A. BUILDING _____ B. WING _____	C 11/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	815 EAST LOCUST STREET DAVENPORT, IA 52803

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F 000	INITIAL COMMENTS The following deficiency relates to the investigation of incident #79668. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C). The facility corrected the immediate jeopardy on October 26, 2018, prior to survey entrance therefore it was considered a past non-compliance immediate jeopardy. A plan of correction and an onsite revisit is not required. Complaint #79679 was not substantiated.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, Advance Registered Nurse Practitioner (ARNP) and staff interviews, the facility failed to ensure one of four residents reviewed remained free of a significant medication error, which resulted in an immediate jeopardy to resident health and safety. (Resident #1) The facility census was 75 residents. Findings include: 1. The Admission Record Report printed November 8, 2017, documented Resident #1 had diagnoses of Schizophrenia and Diabetes Mellitus. The Minimum Data Set assessment dated	F 760	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/21/2018

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.

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F 760	Continued From page 1 8/29/18, documented the resident required extensive assistance with bed mobility, transfers, toilet use and personal hygiene and had short and long term memory problems. The Plan of Care directed staff to administer medications as ordered by the physician. An Incident Report dated 10/26/18 at 5:30 a.m., revealed the resident was administered another resident's medications at 5:30 a.m., resulting in lethargy, altered mental status and further evaluation at the emergency room was required. The Medical Practitioner Progress Note dated 10/26/18 at 12:26 p.m., revealed the resident was seen for sudden onset of drowsiness, slurred speech and unable to understand words (which was not normal). The resident was unable to keep their eyes open during the examination, had increased weakness and decreased strength on the left side. The nurse reported the resident ate all of their breakfast and appeared fine at that time. The pulse saturation level was initially 85 to 86% on room air. Oxygen was applied at 2 Liters and the pulse saturation was up to 94%. During the examination the nurse reported the resident mistakenly received the wrong medications. Further investigation revealed the resident did not receive their own medications. During the assessment and chart review the resident became more lethargic, was unable to respond to questions, was responsive to painful stimuli only, had increased drooling and was unable to hold their head up or control their oral secretions. The resident was transported to the emergency room with the medication list and a list of wrong medications ingested.	F 760		

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F 760	Continued From page 2 The resident ingested Resident #2's medication on 11/7/18. Resident #2's medications included: a. Wellbutrin (antianxiety) 150 milligrams (mg) one tablet. b. Citrus Calcium 200 mg - Vitamin D 3 250 mg tablet. c. Clozapine (antipsychotic) 100 mg tablet. d. Ferrous Sulfate one tablet. e. Magnesium Oxide one tablet. f. Metoprolol tartrate 25 mg tablet. g. Omeprazole 20 mg tablet. h. Therems vitamin one tablet. i. Vitamin D3 1,000 units one tablet. The Discharge Summary revealed the resident was hospitalization from 10/26/18 to 10/28/18 for toxic encephalopathy and possible urinary tract infection. The summary revealed the resident took inappropriate medications and had subsequent unresponsiveness. On Medics arrival the resident responded to painful stimuli, did not answer questions or open their eyes. On arrival to the emergency room the resident had stable vital signs, was somnolent but spontaneously opened their eyes. Laboratory tests revealed the resident had mild lactic acidosis of 2.8 and a Sodium level of 130 (perhaps chronic). Several hours later, the resident was fully conscious and alert and unable to provide history. The resident remained nothing by mouth until mentation improved and the resident was alert. No infectious etiology identified except the resident had positive urine cultures and was treated with ceftriaxone. The resident was afebrile and without leukocytosis or symptoms. During interview on 11/8/18 at 8:16 a.m., Staff B,	F 760		

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F 760	Continued From page 3 licensed practical nurse, LPN reported Staff A, LPN reported she left Resident #1's medications in the resident's room and still needed to administer them before she left. Staff B reported she found medications in a cup on the rail in the hallway. Staff B did not know who the medications belonged to and discarded them. Staff B reported Staff C, certified nurse aide, CNA exited the resident's room and reported finding pills in the residents room. Staff B told Staff C to tell the resident to take the medications. After breakfast Staff C reported to Staff B the resident was not acting right. Staff B reported the resident was alert but not acting right. Staff B had the Nurse Practitioner check on the resident. Then Resident #2 reported they did not receive their morning medications. Staff B reported Staff A should have administered Resident #2's medications. Staff D, registered nurse, RN called Staff A to inquire about Resident #1's medications. Staff B reported she made a poor decision by having the resident take the medications that were left in the room without checking them. During interview on 11/8/18 at 8:39 a.m., the ARNP stated she was with the resident about 20 minutes when asked to examine her. She applied oxygen and was unable to hold her head up and was declining rapidly so she made the decision to send the resident out. During interview on 11/7/18 at 2:43 p.m., Staff D, RN reported calling Staff A to inquire about Resident #2's medications. Staff A reported she left Resident #2's medications in Resident #1's room. Staff D reported that was when they realized what was going on with Resident #1. Staff D reported Staff B reported finding	F 760		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 760	Continued From page 4 medication on the rail in the hall and threw them away. Staff D reported the pills found in the hall were likely Resident #1's medications. During interview on 11/7/18 at 8:56 a.m., Staff C, CNA reported finding medications in Resident #1's room and told Staff B. Staff B directed Staff C to tell the resident to take the pills. Staff C reported she went back in the room and told the resident to take the medications. Staff C reported the resident took the medications. Staff C reported after breakfast the resident was not acting right and reported the behavior to the nurse. During interview on 11/7/18 at 7:27 p.m., Staff A reported Resident #1 yelled out for help as she was about to deliver Resident #2's medications. Staff A entered Resident #1's room with Resident #2's medications and set the medications down on a tray table. Staff A told Resident #1 to wait a minute and she would be back. Staff A remembered she needed to obtain a laboratory specimen for another resident and left the room. Staff A forgot to pick up Resident #2's medications and reported she did not recall setting up Resident #1's medications. The deficiency will be considered past non-compliance as the facility corrected the deficient practice on October 26, 2018 when they completed an all staff one-on-one skills inservice regarding medication administration. Education included do not leave medications at bedside, do not have someone else give your medications and give medications to the resident that is prescribed the medications. The facility reinforced the Medication	F 760		

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F 760	Continued From page 5 Administration policy dated 3/2010, to ensure staff knew to take the medication to the resident, call the residents name, check the residents identification, look at resident photo, describe the medications and what the medication is for to the resident, administer the medication as physician ordered, remain with the resident until the medication is taken and document on the medication administration record.	F 760		