STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165146	A. BUILDING _____ B. WING _____	C 01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

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F 000	INITIAL COMMENTS Correction Date: _____ The facility's self-reported incident #87737-I, investigated 1/6/20 - 1/7/20 was substantiated and resulted in the following deficiency. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 760 SS=G	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 observation, record review, staff, resident and family member interviews, the facility failed to prevent a significant medication error that required transfer to the hospital Emergency Room (ER) for treatment and hospitalization for Resident #1. The facility reported a census of 107 residents. Findings include: The 12/31/19 Minimum Data Set (MDS) Assessment tool revealed Resident #1 admitted to the facility on 12/30/19 with diagnoses that included non-Alzheimer's dementia, acute appendicitis, asthma, dependence on supplemental oxygen and restless leg syndrome (RLS). Noted cognitive assessment not completed, and required assistance of 1 staff to reposition in bed, transfer to and from bed and chair, ambulation, toileting and personal hygiene. Physician orders dated 12/30/19 directed admission to the facility post appendectomy, the	F 760		

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

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resident allergic to Gabapentin (anti-seizure medication also used for treatment of neuropathy pain and RLS), Requip (a dopamine agonist to treat RLS), Xanax (anti-anxiety medication) and Latex, and staff to administer medications that included:

1. Albuterol Sulfate (a bronchodilator) 2.5 milligrams (mg) in 3 milliliter (ml) solution via nebulizer inhalation every 4 hours as needed.
2. Aricept (a cholinesterase inhibitor used for Alzheimer's disease treatment) 5 mg oral daily.
3. Aspirin 81 mg tablet oral daily.
4. Symbicort (corticosteroid used for asthma) 2 puffs inhaled orally twice daily.
5. Benadryl (antihistamine) 50 mg administered oral daily at bedtime for insomnia.
6. Singulair (anti-inflammatory medication for asthma treatment) 10 mg administered oral daily.
7. Prednisone (steroid) 10 mg administered oral daily as needed for asthma.
8. Spiriva (anticholinergic medication for asthma) 2 puffs inhaled oral daily.
9. Hydrocodone-acetaminophen 5-325 mg (Vicodin, a strong narcotic analgesic) 1 tablet administered oral every 4 hours as needed.

Vital signs recorded at 9:20 p.m. upon the resident's 12/30/19 admission were blood pressure 135/75 millimeters mercury (mmHg), pulse 88 and respirations 18 per minute, oxygen saturation of 94 percent with oxygen administered at 2 liters per minute per nasal cannula.

A Medication Error Report form dated 12/31/19 stated Resident #1 received medications ordered and intended for another resident (Resident #2), that included blood pressure medications and Gabapentin, identified as an allergy.

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The nurse, Staff A, Licensed Practical Nurse (LPN), administered the following medications in error:

1. Atorvastatin (medication that decreases cholesterol) 40 mg tablet.
2. Isosorbide Mononitrate ER (extended release medication that prevents angina) 60 mg tablet.
3. Magnesium Oxide (magnesium supplement) 400 tablet.
4. Coumadin (blood thinner) 3 mg tablet.
5. Metroprolol (beta-blocker that reduces blood pressure) 50 mg tablet.
6. Senna Plus 8.6/50 mg (stool softener) 1 tablet.
7. Sotalol (beta-blocker that reduces blood pressure) 40 mg tablet.
8. Gabapentin 100 mg tablet.

A Nurse's Note transcribed at 10:53 a.m. on 12/31/19 revealed blood pressure 88/50 mmHg, the nurse practitioner notified and ordered the resident's transfer to the ER, the next entry at 11:08 a.m. revealed the resident transferred to the hospital via ambulance.

A hospital ER Progress Note dated 12/31/19 revealed the resident treated for hypotension that resulted from a medication error at the nursing home, intravenous fluids with continuous monitoring and hospitalization required.

The facility's Medication Administration Policy, dated as last reviewed 10/25/19, directed:
1. The individual administering medications must verify the resident's identity before giving the resident his/her medication.
2. Methods of identifying the resident included checking the photograph attached to the

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medication record, calling the resident by name, and utilizing other staff to assist in the identification of the resident.

Staff interviews revealed:

1/6/20 at 2:31 p.m., Staff A, LPN, stated she worked the day shift (6:00 a.m. to 2:00 p.m.) on 12/31/19, and a chaotic day. There were several new residents, the 2 Certified Nursing Assistants (CNA's) assigned to the unit new and unfamiliar with resident routines and she had multiple interruptions when she administered morning medications to the residents assigned to her that day. Both Resident #1 and Resident #2 admitted the evening before and neither had a photo on their Medication Administration Record (MAR), one way that staff could ensure they had the right resident when they administered medication. Between 8:00 a.m. and 8:30 a.m., Resident #1 seated in a wheel chair in her room, the resident's name observed on the nameplate in the hall by her door. Staff A prepared Resident #2's medications, walked into Resident #1's room, called the resident by Resident #2's name, Resident #1 said "yes", she administered the medications to the resident who did not say anything else, and she documented Resident #2's medications were administered on the MAR. Staff A stated between 9:00 a.m. and 9:15 a.m., as she prepared Resident #1's medications, she realized she had made the mistake, contacted the Nurse Practitioner and the Director of Nursing (DON) right away, assessed the resident's blood pressure noting to be low and completed the actions required to transfer the resident to the hospital. Staff A reported being a nurse 18 years and never made a medication error until this.

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1/6/20 at 4:38 p.m., Staff B, LPN, stated she worked on an as needed basis. When she administered medications, she asked the resident's name, she has asked other staff on duty to help her identify residents, looked for residents in their room and if in doubt would call the Nursing Supervisor.

1/7/20 at 7:40 a.m., Staff C, Certified Medication Aide (CMA), stated if there was a new resident she would identify them by the photo, ask the resident their name if able to say it, and ask other staff to identify the resident.

1/7/20 at 8:06 a.m., Staff D, LPN, stated if a new resident he would check their photo, although sometimes there was not one, would ask the resident their name if able to say it. Also, ask other staff if they could identify the resident and look for the resident in their room when he completed medication administration for new residents.

1/7/20 at 8:36 a.m., Staff E, Registered Nurse (RN), stated if administering medications to a new resident she would ask the resident their name, check the photo although sometimes there was not a photo if the resident admitted the day before. Also, ask other staff if they knew the resident, check for the resident in their room, and knows the other residents well enough that she would recognize a new face. Staff E reported could also ask the Unit Manager for assistance to identify a resident.

1/6/20 at 9:55 a.m., the Director of Nursing (DON), stated when staff administered medications, she expected them to look at the resident's photo on the MAR, check the name on

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the resident's door, and ask other staff to assist to identify the correct resident. All nursing staff educated after the error occurred.

1/7/20 at 11:10 a.m., the DON and Administrator stated in the future if multiple admissions on the same day, they would not put them in neighboring rooms. They recognized that on the day the error occurred, the Unit Manager was off, the two CNA's were not familiar with the residents or the routine on that unit and they would have approached Staff A with all questions and caused frequent interruptions. They also reported going to educate staff not to interrupt the nurse when at the medication cart or in process of medication administration.

On 1/6/20, the resident's family member and responsible party stated the facility notified them of the medication error, the ER had to contact a poison control center in order to treat one of the medications that the resident received in error, and the hospital transferred the resident to another facility on 1/3/20.