IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER

Complaint Intake #: 49420-C

December 19, 2014

Ms. Jean Parrish, Director
Prime Living Apartments
725 Pearl Street
Sioux City, IA 51101

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION & COMPLAINT/INCIDENT INVESTIGATION REPORT - PRIME LIVING APARTMENTS
II. Reduction of Civil Penalty
III. Informal Conference
IV. Standard Certification
V. Conclusion

Dear Ms. Parrish:

I. Final Recertification & Complaint/Incident Investigation Report – Prime Living Apartments, Sioux City, IA

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **December 2, 3 and 4, 2014.** The complaint alleged policies and procedures were not followed. The complaint was substantiated related to medications and details are contained in the enclosed report. The Report notes Regulatory Insufficiencies in the area(s) of: Program Policies and Procedures, Medications, Evaluation of Tenant, Service Plans, Nurse Review and Food Service.

Prime Living Apartments ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, Program staff gave Tenant incorrect medications leading to acute renal failure resulting in the Tenant being admitted to the intensive care unit at the hospital.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **six hundred and fifty dollars ($650)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0245** with effective dates of **October 27, 2014** through **October 26, 2016**.

V. Conclusion

The Program is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0245	A. BUILDING: _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME LIVING APARTMENTS	725 PEARL STREET SIOUX CITY, IA 51103

(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. *General Population Program* No. of tenants without cognitive disorder: 55 No. of tenants with cognitive disorder: 0 Total Population of Program at time of visit 55 An investigation into Complaint #49420-C and a recertification visit were completed during the onsite visit 12-2 through 12-4-14.	A 000		
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: Complaint # 49420-C alleged a tenant was given medications intended for another tenant. Based on interviews, six record reviews, policy review, and incident reports the program received a regulatory insufficiency for not following its policies and procedures. 1. Tenant #3, an 82 year-old, was admitted on	A 003		

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A 003	Continued From page 1 6-14-14 and had diagnoses of: diabetes, valvular heart disease, peripheral vascular disease, chronic obstructive pulmonary disease, history of prostate cancer, vascular dementia, and hypertension. Tenant #3 was staged at two on the Global Deterioration Scale which indicated very mild cognitive decline. An incident report dated 8-3-14 and timed at 6:52 p.m. documented staff saw Tenant #3 stumbling up the front door outside. Tenant #3 stated he/she was taking out the trash and fell. The incident report documented Tenant #3 was confused and sleepy. Tenant #3 was taken to the hospital. According to documentation from the hospital, Tenant #3 was admitted on 8-3-14 and discharged on 8-5-14. The documentation indicated Tenant #3 was given two narcotic tablets, a muscle relaxant, an anticonvulsant, an antidepressant, and an antihypertensive. The documentation indicated Tenant #3 was found to have a low blood pressure, a low blood sugar, and many of the medications given had sedative qualities. According to the documentation in the physician's hospital note, the antihypertensive medication was in addition to the antihypertensive medication Tenant #3 regularly took, which resulted in acute renal failure. According to the physicians note, Tenant #3 was admitted to the intensive care unit as Tenant #3 was very confused. A CT scan of the head was completed. It was also documented Tenant #3 had low blood sugars, and insulin was held. In an interview with the RN on 12-3-14 at 12:30 p.m. she stated she was unaware medications had been given incorrectly, until the evening of	A 003		

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A 003	Continued From page 2 8-3-14. The RN stated an internal investigation revealed Staff F had administered pills to Tenant #3 intended for another tenant. On the evening of 8-2-14 Staff F was being oriented to work at the program by Staff G. Staff G instructed Staff F to go to the med cart, and give medications from a purple box to Tenant #3. The purple medication box was labeled with a tenant's name, but Staff F did not look at the name on the box prior to administering the pills. Staff F was also being oriented, but by a different staff member on the night of 8-3-14. During the medication pass with the other staff, Staff F realized the wrong medication may have been given to Tenant #3 the day before. After Tenant #3 exhibited the confusion, fall, and sleepiness, Staff F brought it to the attention of the RN. The RN stated she then took steps to notify the hospital of the possible medication error. The RN reported Staff F and Staff G are no longer employed at the program. The RN stated Staff F took the pill box from the medication cart and administered the medication without looking at the name on the box. The RN had not delegated Staff F to pass medications. According to page 37 of the Health Service Policy and Procedure Manual entitled General Guidelines for Medication Assistance, only employees who have received training from the RN may assist with medications. According to the Medication Performance Evaluation, medication packs were to be checked for the correct tenant name, dose, frequency and time.	A 003		

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A 003	Continued From page 3 The program's policy and procedure for medication administration was not followed which resulted in Tenant #3 receiving medications intended for another tenant and admission to the hospital for care related to the side effects of the medications. 2. Tenant #6, a 69 year-old, was admitted on 10-29-10 and had diagnoses of: depression, bipolar, Barretts esophageal reflux, and anxiety. An incident report dated 10-10-14 documented between 10-2-14 and 10-9-14 Tenant #6 had been receiving five milligrams of Benztropine (an antiparkinsons agent) daily instead of the correct three milligrams daily. A medication order was received from the physician dated 10-2-14 to give Benztropine, one milligram tablet, three times a day. The order specified the medication was to be given twice a day and the third dose at bedtime for restless legs. The order was noted by Staff H and was noted with time, date, and signature. A review of the October 2014 medication administration record (MAR) documented the Benztropine was transcribed as ordered. The transcription did not contain the time, date, or signature of the person transcribing the order. A further review of the MAR indicated Benztropine was already listed on the MAR with an original order date of 6-11-12. The MAR indicated Benztropine was to be given as one tablet twice a day. The documentation on the MAR indicated the medication had been discontinued on 10-2-14. The discontinued notation did not include a time or signature. The documentation of the discontinuation of the drug did not occur until after two doses had been given every day	A 003		

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A 003	Continued From page 4 October 1 through October 8. Documentation on the MAR indicated two milligrams of Benztropine was given daily as ordered on 6-11-12 and three milligrams of Benztropine was given in addition beginning the evening of 10-2-14. Staff H was interviewed on 12-3-14 at 2:41 and stated she noted Tenant #6's order for Benztropine on 10-2-14. Staff H made a handwritten entry on the MAR with the new order. Staff H stated she did not pull the old bubble packs from the medication cart and did not check the MAR for existing orders for Benztropine. According to page 22 of the Health Service Policy and Procedure Manual entitled Change of Orders, the prior order was to be discontinued on the MAR by highlighting, writing D/C, initial, and and date. The program's policy on change of medication orders was not followed resulting in Tenant #5 receiving five milligrams of medication daily, rather than the three ordered, for six days.	A 003		
A 036	481-67.5(6)a 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: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule	A 036		

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A 036	Continued From page 5 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Complaint # 49420-C alleged a tenant was given medications intended for another tenant. Based on interviews, six record reviews, policy review, and incident reports the program received a regulatory insufficiency for not administering medications in accordance with subrule 67.9(4). 1. Tenant #3, an 82 year-old, was admitted on 6-14-14 and had diagnoses of: diabetes, valvular heart disease, peripheral vascular disease, chronic obstructive pulmonary disease, history of prostate cancer, vascular dementia, and hypertension. Tenant #3 was staged at two on the Global Deterioration Scale which indicated very mild cognitive decline. An incident report dated 8-3-14 and timed at 6:52 p.m. documented staff saw Tenant #3 stumbling up the front door outside. Tenant #3 stated he/she was taking out the trash and fell. The incident report documented Tenant #3 was confused and sleepy. Tenant #3 was taken to the hospital. According to documentation from the hospital, Tenant #3 was admitted on 8-3-14 and discharged on 8-5-14. The documentation indicated Tenant #3 was given two narcotic tablets, a muscle relaxant, an anticonvulsant, an	A 036		

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A 036	Continued From page 6 antidepressant, and an antihypertensive. The documentation indicated Tenant #3 was found to have a low blood pressure, a low blood sugar, and many of the medications given had sedative qualities. According to the documentation in the physician's hospital note, the antihypertensive medication was in addition to the antihypertensive medication Tenant #3 regularly took, which resulted in acute renal failure. According to the physicians note, Tenant #3 was admitted to the intensive care unit as Tenant #3 was very confused. A CT scan of the head was completed. It was also documented Tenant #3 had low blood sugars, and insulin was held. In an interview with the RN on 12-3-14 at 12:30 p.m. she stated she was unaware medications had been given incorrectly, until the evening of 8-3-14. The RN stated an internal investigation revealed Staff F had administered pills to Tenant #3 intended for another tenant. On the evening of 8-2-14 Staff F was being oriented to work at the program by Staff G. Staff G instructed Staff F to go to the med cart, and give medications from a purple box to Tenant #3. The purple medication box was labeled with a tenant's name, but Staff F did not look at the name on the box prior to administering the pills. Staff F was also being oriented, but by a different staff member on the night of 8-3-14. During the medication pass with the other staff, Staff F realized the wrong medication may have been given to Tenant #3 the day before. After Tenant #3 exhibited the confusion, fall, and sleepiness, Staff F brought it to the attention of the RN. The RN stated she then took steps to notify the hospital of the possible medication error.	A 036		

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A 036	Continued From page 7 The RN reported Staff F and Staff G are no longer employed at the program. The RN stated Staff F took the pill box from the medication cart and administered the medication without looking at the name on the box. The RN had not delegated Staff F to pass medications. According to page 37 of the Health Service Policy and Procedure Manual entitled General Guidelines for Medication Assistance, only employees who have received training from the RN may assist with medications. According to the Medication Performance Evaluation, medication packs were to be checked for the correct tenant name, dose, frequency and time. The program's policy and procedure for medication administration was not followed which resulted in Tenant #3 receiving medications intended for another tenant and admission to the hospital for care related to the side effects of the medications. 2. Tenant #6, a 69 year-old, was admitted on 10-29-10 and had diagnoses of: depression, bipolar, Barretts esophageal reflux, and anxiety. An incident report dated 10-10-14 documented between 10-2-14 and 10-9-14 Tenant #6 had been receiving five milligrams of Benztropine (an antiparkinsons agent) daily instead of the correct three milligrams daily. A medication order was received from the physician dated 10-2-14 to give Benztropine, one milligram tablet, three times a day. The order specified the medication was to be given twice a	A 036		

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A 036	Continued From page 8 day and the third dose at bedtime for restless legs. The order was noted by Staff H and was noted with time, date, and signature. A review of the October 2014 medication administration record (MAR) documented the Benztropine was transcribed as ordered. The transcription did not contain the time, date, or signature of the person transcribing the order. A further review of the MAR indicated Benztropine was already listed on the MAR with an original order date of 6-11-12. The MAR indicated Benztropine was to be given as one tablet twice a day. The documentation on the MAR indicated the medication had been discontinued on 10-2-14. The discontinued notation did not include a time or signature. The documentation of the discontinuation of the drug did not occur until after two doses had been given every day October 1 through October 8. Documentation on the MAR indicated two milligrams of Benztropine was given daily as ordered on 6-11-12 and three milligrams of Benztropine was given in addition beginning the evening of 10-2-14. Staff H was interviewed on 12-3-14 at 2:41 and stated she noted Tenant #6's order for Benztropine on 10-2-14. Staff H made a handwritten entry on the MAR with the new order. Staff H stated she did not pull the old bubble packs from the medication cart and did not check the MAR for existing orders for Benztropine. According to page 22 of the Health Service Policy and Procedure Manual entitled Change of Orders, the prior order was to be discontinued on the MAR by highlighting, writing D/C, initial, and and date.	A 036		

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A 036	Continued From page 9 The program's policy on change of medication orders was not followed resulting in Tenant #5 receiving five milligrams of medication daily, rather than the three ordered, for six days.	A 036		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant ' s continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by. Based on six record reviews and interviews evaluations were not completed with a significant change of condition. 1. Tenant #1, a 63 year-old, was admitted on 9-18-10 and had diagnoses of: schizoaffective disorder, post-traumatic stress disorder, borderline personality, hypertension, gastroesophageal reflux disease, migraines depression, and anxiety.	A 037		

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A 037	Continued From page 10 Service notes dated 8-18-14 documented Tenant #1 was having increased signs and symptoms of depression due to frequent migraines and isolation in the apartment. The notes documented Tenant #1 began feeling suicidal and decided to admit self to the hospital. Tenant #1 refused ambulance transfer and drove self to the hospital. Service notes dated 8-26-14 documented Tenant #1 returned to the Program. The service notes documented cognition, health, and function was "back to stable;" however, evaluations of function, cognition, and health were not completed. Tenant #1 admitted self for suicidal ideation, a potential for harm to self, and a change of condition. Evaluations were not completed upon return from the hospital with a change of condition to determine Tenant #1's continued eligibility for the program and to determine any changes to services provided. Service notes dated 9-5-14 documented Tenant #1 was started on an antibiotic for folliculitis of the abdomen. Evaluation of the condition of the abdomen was not completed with a change of condition Service notes dated 8-18-14 documented Tenant #1 had increased signs and symptoms of depression due to frequent migraines and isolation in the apartment. Notes of 10-31-14 documented Tenant #1 complained of a migraine. The service notes of 10-31-14 documented Tenant #1 had used pain medication, a medication for migraines, and a medication for nausea that were ineffective. Tenant #1 drove self to the emergency room for further care.	A 037		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	S0245	A. BUILDING: _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME LIVING APARTMENTS	725 PEARL STREET SIOUX CITY, IA 51103

(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 037	Continued From page 11 Service notes dated 11-11-14 documented Tenant #1 called a cab to go to the emergency room again for the migraine. Notes of 11-14-14 documented Tenant #1 continued to complain of headaches, sleeping a lot, and having thoughts of not wanting to wake up. Tenant #1 was described as more depressed. Tenant #1 admitted self to the hospital. Documentation from the hospital revealed Tenant #1 was admitted to the hospital on 11-14-14 and was discharged on 11-20-14. Tenant #1 was hospitalized for suicidal ideation. Staff I was interviewed on 12-3-14 at 9:33 a.m. and identified Tenant #1 as a person with suicidal thoughts. Service notes dated 11-20-14 documented Tenant #1 was "a little better" but the headaches continued. Evaluations were not completed with a change of condition to determine Tenant #1's continued eligibility for the program and to determine any changes to services provided. 2. Tenant #2, a 56 year-old, was admitted on 8-28-14 and had diagnoses of: diabetes, osteomyelitis with Methicillin Resistant Staphylococcus Aureus (MRSA), morbid obesity, diabetic neuropathy, gastroesophageal reflux disease, chronic kidney disease stage 3, bilateral lower extremity cellulitis, asthma, and sleep apnea. Service notes dated 8-28-14, the day of admission to the Program, documented Tenant #2 had a history of ulcerations to the left foot with osteomyelitis and MRSA. Tenant #2 was to take antibiotics and be seen at a wound clinic.	A 037		

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A 037	Continued From page 12 According to service notes dated 10-16-14, Tenant #2 reported a fall, hitting the head on a table. Tenant #2 was also dizzy, lightheaded, cold, and clammy. Tenant #2 was transported to the hospital. Service notes dated 10-20-14 documented Tenant #2 returned to the Program following admission for pneumonia, dizziness, and dehydration. The notes documented Tenant #2 was "very hypoxic" requiring oxygen continuously. Evaluations did not reveal how it was determined Tenant #2 was "very hypoxic" Evaluations in the service notes and on the health/functional assessment form did not include documentation of an assessment of Tenant #2's lung status or respiratory rate following hospital admission for pneumonia. Evaluations were not completed with a change of condition. Discharge instructions dated 10-20-14 documented Tenant #2 had wounds on the right leg and left heel and dressing changes were required. The service notes dated 10-20-14 documented there was no visible wound on the right leg, and that wound continued on the left lower extremity. In an interview with the RN on 12-3-14 at 4:30 p.m., she stated the wound was being cared for by an outside agency. A review of the MAR for October-November 2014 documented the Program was cleaning and caring for the wound. Neither the service notes nor the health/functional assessment documented a specific description of the wound, and did not document an evaluation of progress of the wound, as Tenant #2 was admitted to the Program in August with wounds An evaluation of the wounds was not completed to determine whether the "very hypoxic" state affected wound	A 037		

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A 037	Continued From page 13 healing. Evaluations of the leg wound were not completed with a change of condition, pneumonia resulting in a very hypoxic condition. 3. Tenant #3, an 82 year-old, was admitted on 6-14-14 and had diagnoses of: diabetes, valvular heart disease, peripheral vascular disease, chronic obstructive pulmonary disease, history of prostate cancer, vascular dementia, and hypertension. Tenant #3 was staged at two on the Global Deterioration Scale which indicated very mild cognitive decline. An incident report dated 8-3-14 and timed at 6:52 p.m. documented staff saw Tenant #3 stumbling up the front door outside. Tenant #3 stated he/she was taking out the trash and fell. The incident report documented Tenant #3 was confused and sleepy. Tenant #3 was taken to the hospital. According to documentation from the hospital, Tenant #3 was admitted on 8-3-14 and discharged on 8-5-14. The documentation indicated Tenant #3 was given two narcotic tablets, a muscle relaxant, an anticonvulsant, an antidepressant, and an antihypertensive which were not prescribed to Tenant #3. The documentation indicated Tenant #3 was found to have a low blood pressure, a low blood sugar, and many of the medications given had sedative qualities. According to the documentation, Tenant #3's blood sugar reading was 51 and required treatment with a concentrated dextrose solution. According to the documentation in the physician's hospital note, the antihypertensive medication was in addition to the antihypertensive medication Tenant #3 regularly took, which resulted in acute renal failure. Fluids were given to correct the renal failure.	A 037		

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A 037	Continued From page 14 According to the physicians note, Tenant #3 was admitted to the intensive care unit as Tenant #3 was very confused. A CT scan of the head was completed. It was also documented Tenant #3 had low blood sugars, and insulin was held. Tenant #3 returned to the Program on 8-5-14. Tenant #4 exhibited a significant change of condition as a result of being given medications intended for another tenant. Evaluations of function, cognition, and health were not completed following Tenant #3's hospitalization for side effects related to a medication error which resulted in admission to an intensive care unit. Evaluations were not completed with a significant change of condition. 4. Tenant #5, a 57 year-old, was admitted on 11-3-13 and had diagnoses of: hypertension, chronic obstructive pulmonary disease, vitamin D deficiency, avascular necrosis. attention-deficit hyperactivity disorder, bipolar disorder, depression, and borderline personality disorder. Tenant #5 was admitted to the hospital for a revision of a total knee replacement. According to the service notes dated 10-27-14, Tenant #5 had a history of avascular necrosis and frequently needed joint replacements The service notes dated 10-27-14 documented Tenant #5 returned to the Program on that date. According to the health/functional assessment completed on 10-27-14, Tenant #5 was to be monitored for suicidal ideations. The service notes of 10-27-14 documented Tenant #5 would return immediately to an outside service provider for mental health, but would "eventually" return once Tenant #5 felt "up to it."	A 037		

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A 037	Continued From page 15 In an interview with Staff B on 12-3-14 at 9:43 a.m., she identified Tenant #5 as a person with suicidal thoughts. Staff B stated Tenant #5 talked about being overly depressed. The evaluation did not include an assessment of Tenant #5's mental status related to the potential for self-harm at the time of the evaluation. The evaluation did not document an assessment of Tenant #5's surgical site, the right knee. Evaluations were not completed to determine Tenant #5's health status, continued eligibility for the Program, and to determine any changes in services needed. Evaluations were not completed with a change of condition.	A 037		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on six record reviews the program received a regulatory insufficiency in the area of service plans. Service plans did not meet the identified needs of the tenants.	A 083		

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A 083	Continued From page 16 1. Tenant #1, a 63 year-old, was admitted on 9-18-10 and had diagnoses of: schizoaffective disorder, post-traumatic stress disorder, borderline personality, hypertension, gastroesophageal reflux disease, migraines depression, and anxiety. Service notes completed by the RN and dated 8-18-14, documented Tenant #1 was having increased signs and symptoms of depression due to frequent migraines and isolation in the apartment. A connection was made between increased signs of depression and migraines and isolation. Tenant #1 was admitted to the hospital on 8-18-14 for suicidal feelings according to the service notes dated 8-18-14. A review of the service plan dated 2-1-14 did not direct staff members to be alert to Tenant #1's migraines and isolation as a trigger for depression and suicidal thoughts. The service plan did not give specific direction to staff as to when to contact the RN. The service plan did not meet the identified needs of Tenant #1. 2. Tenant #2, a 56 year-old, was admitted on 8-28-14 and had diagnoses of: diabetes, osteomyelitis with Methicillin Resistant Staphylococcus Aureus (MRSA), morbid obesity, diabetic neuropathy, gastroesophageal reflux disease, chronic kidney disease stage 3, bilateral lower extremity cellulitis, asthma, and sleep apnea. Tenant #2 returned from a hospital stay for pneumonia on 10-20-14. Discharge instructions included wound care to a leg wound. The medication administration record for October to November 2014 confirmed staff assistance with wound care which included wound cleaning. The	A 083		

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A 083	Continued From page 17 service plan of 10-20-14 identified staff was to assist with wound care and identified wound cleaning and the history of MRSA. The service plan of 10-20-14 did not identify Tenant #2's allergy to latex as identified on the 10-20-14 discharge instructions. The service plan did not meet the identified needs of Tenant #2. Tenant #2 had been prescribed antibiotics for the chronic leg wound, last prescribed on 10-6-14. The service plan identified staff was to monitor for adverse side effects to medications including vaginal itching or discharge. (Vaginal itching or discharge would not be applicable to Tenant #2 so the intervention was irrelevant.) The service plan was not designed to meet the specific service needs of Tenant #2.	A 083		
A 094	481-69.27(1) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(1) To monitor, at least every 90 days, or after a significant change in the tenant ' s condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. This REQUIREMENT is not met as evidenced	A 094		

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A 094	Continued From page 18 by: Based on six record reviews, the program received a regulatory insufficiency in the area of nurse review. Nurse reviews were not completed every 90 days or with a change of condition related to medications. 1. Tenant #1, a 63 year-old, was admitted on 9-18-10 and had diagnoses of: schizoaffective disorder, post-traumatic stress disorder, borderline personality, hypertension, gastroesophageal reflux disease, migraines depression, and anxiety. Service notes dated 9-5-14 documented Tenant #1 was started on an antibiotic for folliculitis of the abdomen. A nurse review was not completed when the antibiotic was finished to determine if Tenant #1 experienced any adverse reactions to the antibiotic and to determine if the antibiotic was effective in treating the folliculitis. A physician's order dated 10-10-14 documented Tenant #1 was prescribed an antibiotic for ten days after concerns of sinus drainage, ringing in the ears, and dizziness. A nurse review was not completed when the antibiotic was finished to determine if Tenant #1 experienced any adverse reactions to the antibiotic and to determine if the antibiotic was effective in treating the sinus condition. A review of the service plan for Tenant #1 dated 2-1-14, current at the time of the onsite visit, and a review of the medication administration record for September 2014, the program administered medications to Tenant #1. According to a health/functional assessment dated 10-28-14, the quarterly review was completed on that date. According to the notation, the form was originally	A 094		

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A 094	Continued From page 19 completed on 2-1-14, and the form was reviewed on 5-1-14, 7-29-14 and 10-28-14. There was no documentation on 10-28-14 as to whether or not the medication orders were current, that medications were administered consistent with the orders, and whether or not Tenant #1 was experiencing any adverse reaction to the medications. 2. Tenant #5, a 57 year-old, was admitted on 11-3-13 and had diagnoses of: hypertension, chronic obstructive pulmonary disease, vitamin D deficiency, avascular necrosis. attention-deficit hyperactivity disorder, bipolar disorder, depression, and borderline personality disorder. Service notes dated 10-27-14 documented Tenant #5 had a significant change of condition following a total knee replacement and revision due to avascular necrosis. According to the health/functional assessment dated 10-27-14, the Program administered medications to Tenant #5. A nurse review was not completed on 10-27-14 to include the presence or absence of adverse medication reactions, to ensure prescription orders were current, and that medications had been administered consistent with the orders. A nurse review was not completed with a change of condition.	A 094		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse	A 096		

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A 096	Continued From page 20 via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on six record reviews the program received a regulatory insufficiency in the area of nurse review related to the assessment and monitoring of the health status every 90 days and with a change of condition. 1. Tenant #1, a 63 year-old, was admitted on 9-18-10 and had diagnoses of: schizoaffective disorder, post-traumatic stress disorder, borderline personality, hypertension, gastroesophageal reflux disease, migraines depression, and anxiety. Service notes dated 9-5-14 documented Tenant #1 was started on an antibiotic for folliculitis of the abdomen. A nurse review was not completed when the antibiotic was finished to determine Tenant #1's heath status, the condition of the abdomen. A physician's order dated 10-10-14 documented Tenant #1 was prescribed an antibiotic for ten days after concerns of sinus drainage, ringing in the ears, and dizziness. A nurse review was not completed when the antibiotic was finished to determine if Tenant #1's health status, the condition of the sinuses, ringing in the ears, and dizziness. According to a health/functional assessment for	A 096		

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A 096	Continued From page 21 Tenant #1 dated 10-28-14, the quarterly review was completed on that date. According to the notation, the form was originally completed on 2-1-14, and the form was reviewed on 5-1-14, 7-29-14 and 10-28-14. Service notes dated 8-18-14 documented Tenant #1 had increased signs and symptoms of depression due to frequent migraines and isolation in the apartment. Tenant #1 had been admitted to the hospital for suicidal ideation on 8-18-14, treated for folliculitis on 9-5-14 and treated for a sinus condition on 10-10-14. There was no documentation on 10-28-14 as to Tenant #1's mental health status, the course of migraine headaches and isolation over the last 90 days. Tenant #1's progress over the last 90 days was not monitored. 2. Tenant #2, a 56 year-old, was admitted on 8-28-14 and had diagnoses of: diabetes, osteomyelitis with Methicillin Resistant Staphylococcus Aureus (MRSA), morbid obesity, diabetic neuropathy, gastroesophageal reflux disease, chronic kidney disease stage 3, bilateral lower extremity cellulitis, asthma, and sleep apnea. According to service notes dated 10-16-14, Tenant #2 reported a fall, hitting the head on a table. Tenant #2 was also dizzy, lightheaded, cold, and clammy. Tenant #2 was transported to the hospital. Service notes dated 10-20-14 documented Tenant #2 returned to the Program following admission for pneumonia, dizziness, and dehydration. The notes documented Tenant #2 was "very hypoxic" requiring oxygen continuously. The 10-20-14 service plan contained handwritten documentation dated 10-31-14 which indicated	A 096		

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A 096	Continued From page 22 Tenant #2 was no longer using oxygen continuously. A nurse review was not completed when the oxygen was discontinued to document the health status of Tenant #2 and to monitor progress related to the previously recommended continuous oxygen therapy.	A 096		
A 101	481-69.28(3)b Food Service 481-69.28(231C) Food service. 69.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: b. A minimum of 66 2/3 percent if the program provides two meals per day This REQUIREMENT is not met as evidenced by: Based on a review of menus and interview, a regulatory insufficiency was cited as the Program could not determine one-third of the daily nutritional requirements were provided for every meal served at the program. On 12-3-14 at 9:30 a.m. the Director identified Staff E as the person responsible at the program for menu planning. Staff E was interviewed on 12-3-14 at 10:00 a.m. and stated she made the menus following "My Plate" and the food pyramid. Staff E reported the Program served two meals a day Monday through Friday (lunch and supper), and one meal a day on Saturday and Sunday (lunch). Staff E reported milk was served at	A 101		

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A 101	Continued From page 23 every meal offered. Staff E stated based on the "My Plate" and the food pyramid, there should be one serving of fruit and one serving of vegetables at each meal. The program provided copies of menus for lunch and supper for the months of October, November, and December. The lunch menu lacked documentation of a fruit served on 15, and vegetable on 5 of 31 days in October. The supper menu lacked documentation of a fruit served on 17, and vegetable on 2 of 23 days in October. The lunch menu lacked documentation of a fruit served on 14, and vegetable on 4 of 30 days in November, The supper menu lacked documentation of a fruit served on 13, and vegetable on 1 of 19 days in November. The lunch menu lacked documentation of a fruit served on 16, and vegetable on 3 of 31 days in December. The supper menu lacked documentation of a fruit served on 11, and vegetable on 4 of 22 days in December. In an interview with Staff E who prepared the menus, she stated one serving of fruit was to be served at each meal to follow the "My Plate" and food pyramid. The menus did not provide fruit as needed to meet dietary allowances. The menus were not planned to provide 66% of the daily recommended dietary allowances, as the Program provided two meals a day Monday through Friday.	A 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0245	A. BUILDING: _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME LIVING APARTMENTS	725 PEARL STREET SIOUX CITY, IA 51103

(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 104	Continued From page 24	A 104		
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on employee file reviews and interview, a regulatory insufficiency was cited related to lack of annual food safety training. Four employee files were reviewed. Staff A was hired as a universal worker on 8-19-13. Staff training files lacked documentation of an annual inservice on food protection for Staff A. Staff B was hired on 2-13-14 as a universal worker. Staff C was hired on 7-15-14 for garbage duties. Staff training files lacked documentation of an orientation on sanitation and safe food handling prior to handling food. In an interview with the Director, Staff A, Staff B, and Staff C served food or were likely to serve food. Staff training files lacked documentation of food safety training.	A 104		

Program policies and procedures A003

Page 1

Prime has reviewed policy and procedures regarding medication administration and believes that the procedures in place are adequate. Policy clearly states only staff that have been delegated by the RN are to administer medications. The insufficiency is the direct result of an individual staff member decision to blatantly disregard Prime policy and procedure. For this reason, Prime reviewed staff training procedures and has dedicated additional education/teaching in the area of staff training other staff. Additional training reiterates process that while training new staff, senior staff is never to allow that new staff to administer medications (new staff is observation only until RN has delegated medication administration). All staff at Prime living that is allowed to train new staff will be required to review education regarding this situation prior to training new staff. **Attached please find a copy of additional training packet and employee sign off sheet. This training will occur at 01/19/15 all staff, and prior to being scheduled to train new staff members.**

Page 3

Prime has reviewed policy and procedure with regard to transcribing changed orders on the medication administration record (MAR). Policy clearly defines how this process needs to take place. However, staff did not follow procedure. Prime has updated this policy to state that with regard to order changes, 2 staff members will review transcription and procedure prior to RN reviewing the change on MAR. Prime believes with the addition of this added step the procedure will allow a total of 3 staff members to check changes to ensure the transcription is done properly.

Program policies and procedures A036 Page 5/Medications

1. Prime has reviewed policy and procedures regarding medication administration and believes that the procedures in place are adequate. Policy clearly states only staff that have been delegated by the RN are to administer medications. The insufficiency is the direct result of an individual staff member decision to blatantly disregard Prime policy and procedure. For this reason, Prime reviewed staff training procedures and has dedicated additional education/teaching in the area of staff training other staff. Additional training reiterates process that while training new staff, senior staff is never to allow that new staff to administer medications (new staff is observation only until RN has delegated medication administration). All staff at Prime living that is allowed to train new staff will be required to review education regarding this situation prior to training new staff.
2. Prime has reviewed policy and procedure with regard to transcribing changed orders on the medication administration record (MAR). Policy clearly defines how this process needs to take place. However, staff did not follow procedure. Prime has updated this policy to state that with regard to order changes, 2 staff members will review transcription and procedure prior to RN reviewing the change on MAR. Prime believes with the addition of this added step the

procedure will allow a total of 3 staff members to check changes to ensure the transcription is done properly.

Evaluation of Tenant A037 Page 10

Prime Living has reviewed policy and procedure regarding Evaluation of Tenant, the policies and procedures regarding this is clear and follows the guidelines required by the State. Our belief is that the prior Wellness Director did not follow the guidelines set forth. In order to ensure compliance, Prime Living will assign personnel (in addition, and separate from the Wellness Director) to review 3 random charts monthly. In addition to those random charts, charts will be reviewed following return to the facility from any hospital stay. This will provide a check and balance system to ensure that Evaluation of Tenant is taking place according to not only Prime policy and procedure, but state requirements as well. Prime Living is currently in search of both a Registered Nurse and a Licensed Practical Nurse, in the meantime we have employed part time Dawn Bricker, RN, ARNP to complete the job duties of the Wellness Director. **Attached please find random chart audit monthly paperwork. Staff assigned to this task will be the director or designee. Audits will start 02/2015.**

1. Tenant #1 will be re-evaluated by Dawn to ensure eligibility in the program, this will be completed by 01/16/15. Updates to Service plan will be made if applicable.
2. Tenant #2 will be re-evaluated by Dawn to ensure service plan is adequate and needs are being met by 01/16/15. Service notes will reflect current conditions and any care coordination that is taking place. Updates to Service plan will be made if applicable.
3. Tenant #3 will be re-evaluated by Dawn to ensure service plan is reflective of wants and needs of the tenant. This will be completed by 01/23/15. Updates to Service plan will be made if applicable.
4. Tenant #4 will be re-evaluated by Dawn to ensure service plan is in direct correlation of tenant condition. This will be completed by 01/23/15. Updates to Service plan will be made if applicable.
5. **Tenant #5 will be re-evaluated by Dawn to ensure service plan is in direct correlation of tenant condition. This will be completed by 01/23/15. Updates to Service Plan will be made if applicable.**

Service Plans A083 Page 16

Prime Living has reviewed policy and procedure regarding Service Plans, the policies and procedures regarding this is clear and follows the guidelines required by the State. Our belief is that the prior Wellness Director did not follow the guidelines set forth. In order to ensure compliance, Prime Living will assign personnel (in addition, and separate from the Wellness Director) to review 3 service plans monthly. In addition to those random service plans, service plans of tenants will be reviewed follow any hospital stay. This will provide a check and balance system to ensure that Service Plans are accurate to the tenant wants and needs and to ensure updating Service plans is taking place according to not only Prime policy and procedure, but state requirements as well. Prime Living is currently in search of both a Registered Nurse and a Licensed Practical Nurse, in the meantime we have employed part time Dawn

Bricker, RN, ARNP to complete the job duties of the Wellness Director. **Attached please find random chart audit monthly paperwork. Staff assigned to this task will be the director or designee. Audits will start 02/2015.**

1. Tenant #1 will be re-evaluated by Dawn to ensure eligibility in the program, this will be completed by 01/16/15. Updates to Service plan will be made if applicable.
2. Tenant #2 will be re-evaluated by Dawn to ensure service plan is adequate and needs are being met by 01/16/15. Service notes will reflect current conditions and any care coordination that is taking place. Updates to Service plan will be made if applicable.

Nurse Review A096 Page 18

Prime Living has reviewed the policy and procedure for Nurse Review. The policy and procedure is outlined and Prime has determined that it is adequate in accordance to state requirements. It has been determined by Prime that prior nursing staff did not follow these rules and regulations. As with Service plans and Evaluations, changes made to Prime policy and procedure will provide a check and balance system to ensure that nursing personnel are following the required rules, regulations, policies and procedures. Chart audits done to 3 charts monthly as well as a review following return to facility after hospital stay will take place.

1. Tenant #1 will be re-evaluated by Dawn to ensure eligibility in the program, this will be completed by 01/16/15. Updates to Service plan will be made if applicable.

2. Tenant #2 will be re-evaluated by Dawn to ensure service plan is adequate and needs are being met by 01/16/15. Service notes will reflect current conditions and any care coordination that is taking place. Updates to Service plan will be made if applicable.

Food Service A 101 Page 23

Staff E has successfully completed Serve Safe training. Prime continues to utilize the "My Plate" guidelines, however the guidelines for this have be reviewed by additional personnel and additional paperwork has been developed in order to ensure those guidelines are being met. An easy to read break down has been developed to ensure that all staff can understand the necessary requirements. In addition, Prime has added offering juice at each meal. The addition of offering juice at meals will help Prime to offer the minimum 66 2/3 percent that we are required to do. Menus have been changed to add the addition of offering fruit and/or vegetable juices.

01/15/2015 Staff Mentoring or Training

Additional training for staff members responsible for mentoring/training new personnel.

Attached please find policies and procedures regarding medication administration, review the information and initial the bottom of page if you understand and agree to follow these guidelines.

Remember, **no one** is allowed to dispense medications prior to nurse delegation. Plain and simply this means that **until a new employee has been "tested out" by the nurse they are not under any circumstances to administer any medications independently.** This means, that you can't leave them to answer another pendant call, check another tenant, grab a soda, have a cigarette, etc. For work reasons or personal reason, when training a new staff member you can't leave them to dispense medications.

I have reviewed the information regarding medication administration, I understand that I am responsible for training new staff members. I accept that I am held accountable for following the policies and procedures set forth by Prime Living.

Name:_____ date: _____

Name:_____ date: _____

Name:_____ date: _____

Name:_____ date:_____

Name:_____ date:_____

Name:_____ date:_____

Nurse review chart audits

Tenant: _____

Attached please find a copy of a guide to follow regarding process or change of condition/nurse review/service plan updates, etc. Audits are completed to ensure the safety and well-being of the tenant.

Last hospitalization & dx for stay. New orders, did tenant return with an increase in service hours? Any new diagnosis?

_____

_____

_____

_____

Review last month of service documentation, communication reports, and incident reports. Are there any changes made to service plan, care logs? Any antibiotic therapy?

_____

_____

_____

_____

Last evaluation? _____

Last GDS/Mini Mental?_____

Last minutes update?_____

Last change of condition/nurse review?_____

_____

Name of person completing report

_____

Director/designee

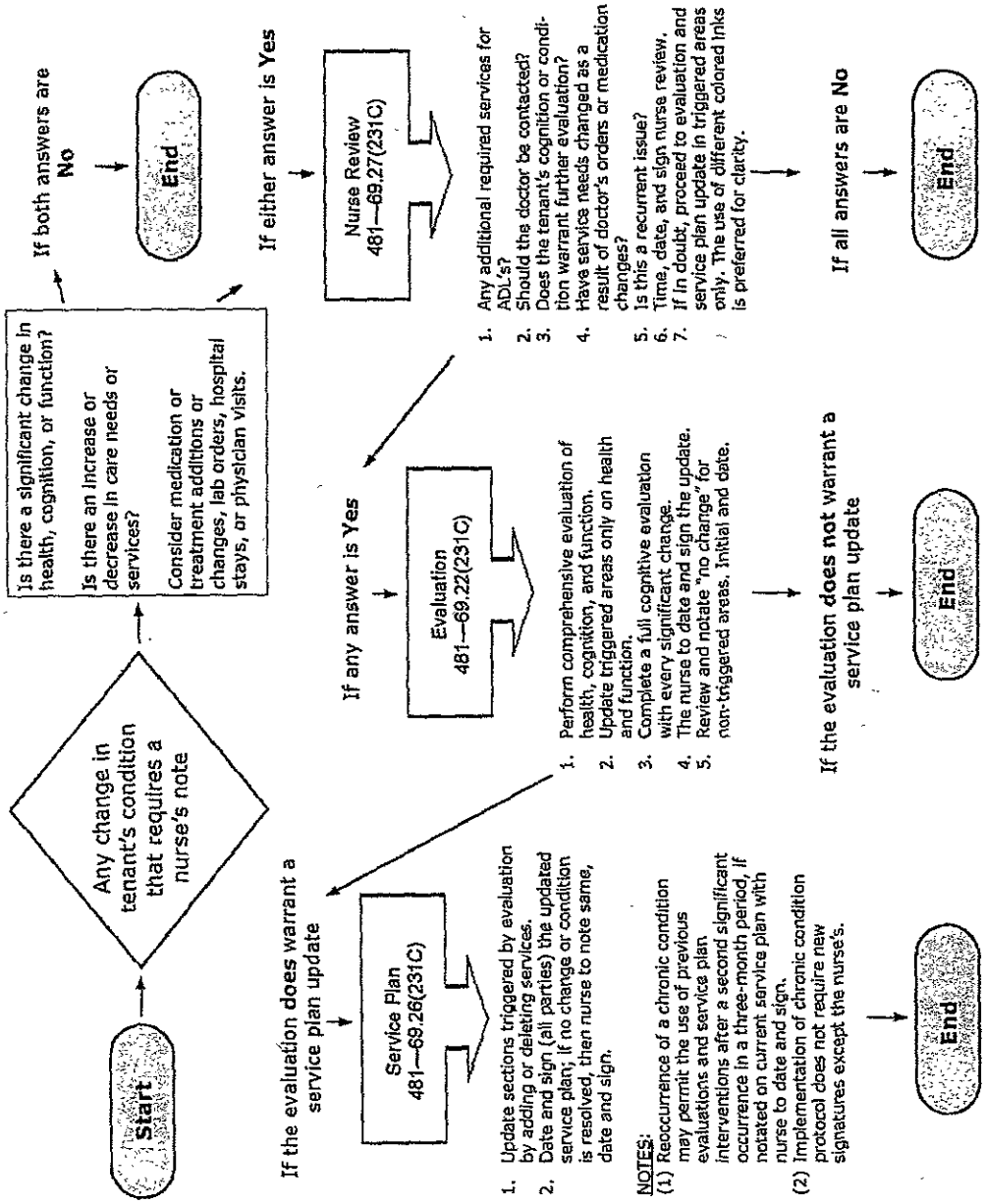
living program to persons requiring a level of care which is higher than the level of care the program is certified to provide.

69.39(9) *Accessibility by the department.* The department shall have the same access to respite care services records as provided in 481—subrule 67.10(2).

[ARC 1667C, IAB 10/15/14, effective 11/19/14]

These rules are intended to implement Iowa Code chapter 231C.

Table A



[Filed ARC 8176B (Notice ARC 7878B, IAB 6/17/09), IAB 9/23/09; effective 1/1/10]
[Filed ARC 1376C (Notice ARC 1291C, IAB 1/22/14), IAB 3/19/14, effective 4/23/14]
[Filed ARC 1667C (Notice ARC 1511C, IAB 6/25/14), IAB 10/15/14, effective 11/19/14]

01/15/2015 Staff Mentoring or Training

Completed Jan 19th

Additional training for staff members responsible for mentoring/training new personnel.

Attached please find policies and procedures regarding medication administration, review the information and initial the bottom of page if you understand and agree to follow these guidelines.

Remember, **no one** is allowed to dispense medications prior to nurse delegation. Plain and simply this means that **until a new employee has been "tested out" by the nurse they are not under any circumstances to administer any medications independently.** This means, that you can't leave them to answer another pendant call, check another tenant, grab a soda, have a cigarette, etc. For work reasons or personal reason, when training a new staff member you can't leave them to dispense medications.

I have reviewed the information regarding medication administration, I understand that I am responsible for training new staff members. I accept that I am held accountable for following the policies and procedures set forth by Prime Living.

Name:_____ date: _____

Name:_____ date: _____

Name:_____ date: _____

Name:_____ date:_____

Name:_____ date:_____

Name:_____ date:_____

4. STAFF ASSISTANCE WITH MEDICATION ADMINISTRATION

GENERAL GUIDELINES FOR MEDICATION ASSISTANCE

POLICY: Staff should follow established procedures when providing tenants assistance with medication administration.

PROCEDURES:

1. Only designated employees who have received training from the RN may assist with medications.

2. Upon hire all staff will sign Master Signature Key during orientation.

3. If a tenant has difficulty taking his/her medication(s), the RN should consider options that might make the medication easier for him/her to take (be sure to obtain feedback from the tenant's physician and/or pharmacist as appropriate). Possible alternatives might include:

   - Crushing a tablet and mixing it in food such as applesauce (this often works well if the tenant has said the medication has a bitter taste). This may not be done, however, without the tenant's knowledge or against his/her will.

   - Cutting a tablet in half if the tenant has a difficult taking the entire tablet.

   - Obtaining the medication in liquid form if available (liquids are usually easier to take).

   - Finding a more acceptable time to take the medication (e.g., later in the day when the tenant is not as groggy).

4. Medications should not be used to address behavioral issues unless other approaches have been tried first (e.g., behavior management techniques) and the medication has been ordered by the physician for this purpose. Documentation of all approaches tried, along with the corresponding results should be documented in the tenant's Service Notes, and a Behavior Management Plan should be developed when appropriate (see the section on Behavior Management Plans in the Occupancy Policy and Procedure manual).

ASSISTING WITH ROUTINE MEDICATIONS

POLICY: Staff shall assist tenants with the administration of routine medications in a manner according to established procedures.

PROCEDURES:

1. When assisting a tenant with a medication, a staff member should:

   - Read the information regarding the medication in the tenant' medication record (i.e., the medication name, dosage and time the medication is to be taken).

   - Read the medication label (i.e., the medication name, dosage and time the medication is to be taken).

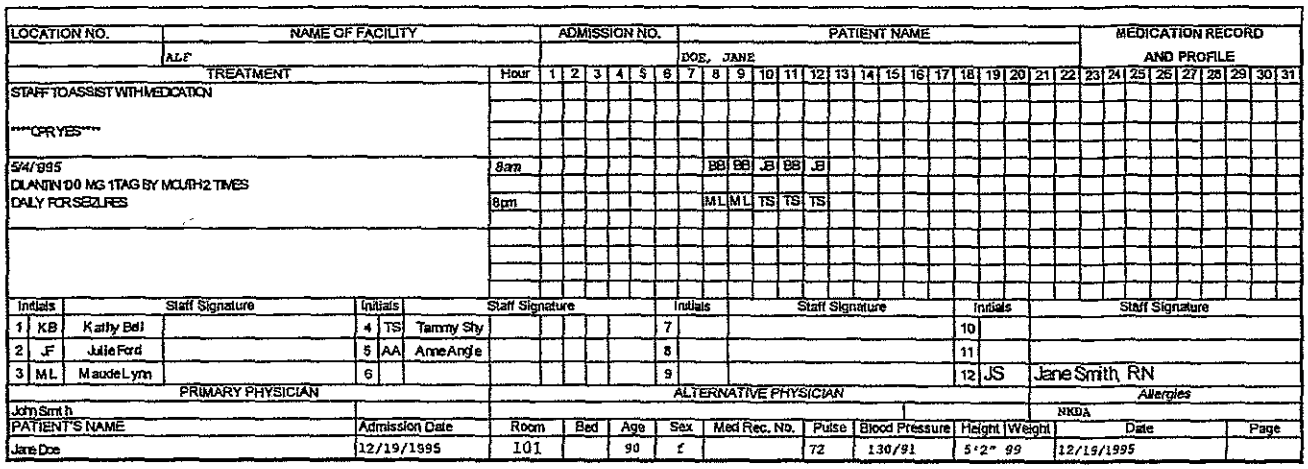
   - Read the information in the medication record – again – and on the label – again.

   - Ensure that the information on the medication record and the medication label match EXACTLY. If the information in the medication book does not match that on the medication label EXACTLY, contact the RN before assisting the tenant with that medication.

2. If using a bubble-packed system the staff person should then:

   - Punch (i.e., "pour") the medication(s) into the medication cup, from the bubble on the card that corresponds to the current date (e.g., on the 20th of the month, the medication should be punched from the bubble marked with a 20, on the 21st from the bubble marked with a 21, etc.)

Example:



LOCATION NO.	NAME OF FACILITY	ADMISSION NO.	PATIENT NAME	MEDICATION RECORD AND PROFILE
	ALF		DOE, JANE	

TREATMENT	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
STAFF TO ASSIST WITH MEDICATION																																
****CPR YES****																																
5/4/1995	8am								BB	BB	JB	BB	JB																			
DILANTIN 100 MG 1TAB BY MOUTH 2 TIMES DAILY FOR SEIZURES	8pm								ML	ML	TS	TS	TS																			

Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature
1 KB	Kathy Bell	4 TS	Tammy Shy	7		10	
2 JF	Julie Ford	5 AA	Anne Angle	8		11	
3 ML	Maude Lynn	6		9		12 JS	Jane Smith, RN

PRIMARY PHYSICIAN	ALTERNATIVE PHYSICIAN	Allergies
John Smith		NKDA

PATIENT'S NAME	Admission Date	Room	Bed	Age	Sex	Med Rec. No.	Pulse	Blood Pressure	Height	Weight	Date	Page
Jane Doe	12/19/1995	101		90	f		72	130/91	5'2"	99	12/19/1995	

- Punch any additional medication(s) for that tenant for the appropriate assistance time into the cup marked with the tenant's initials and apartment number.

- Hand the medication cup to the tenant. Be sure to observe the tenant taking his/her medication (i.e., do not leave the medication with the tenant for him/her to take at a later time).

- Initial on the tenant's medication record in the square for the appropriate assistance time for the medication, in the column for the current day.

3. If a multi-dose packaging system is used, the staff member should:

   - Follow the instruction in #1 above (i.e., comparing the information on the medication book with that on the label).

   - Have the tenant remove the medication from the container if he/she is able. If the tenant is not able to do this, assist the tenant as needed in removing the medication from the container.

   - Observe the tenant taking the medication (do not leave the medication with the tenant).

   - Initial in the appropriate square(s) on the tenant's medication record in the column for the current day, for the appropriate assistance time for each medication in the multi-dose container.

4. If a tenant refuses a medication, offer it again, as indicated on the medication record (e.g., some medication must be taken before meals). There is usually a window of time (typically one hour on either side of the assistance time noted on the medication record) during which it is acceptable to give the medication. If the medication is not taken within this time frame, follow the procedures in the "Refused Medications" section of this manual. If unsure of the appropriate window of time in which a medication may be re-offered, call the RN.

ASSISTING WITH PRN MEDICATIONS

POLICY: Staff shall assist tenants with PRN medications in accordance with State regulations and established policy.

PROCEDURES:

1. Physicians' orders for PRN medications should include the specific symptoms that indicate the need for the medication, the exact dosage, the minimum number of hours between doses, and the maximum number of doses to be given in a 24-hour period. This information should also be on the medication label.

2. When a PRN medication is given, the staff member who has been designated and trained to perform this task should:

   - Read the information regarding the medication in the tenant's medication record (i.e., the medication name, dosage and time the medication is to be taken).

   - Read the medication label (i.e., the medication name, dosage and time the medication is to be taken).

   - Read the information in the medication record – again – and on the label – again.

   - Ensure that the information on the medication record and the medication label match EXACTLY. If the information in the medication book does not match that on the medication label EXACTLY, contact the RN before assisting the tenant with that medication.

3. ***If using a bubble-packed system the staff person should then***:

- Punch the specified medication(s) into the medication cup (PRN medication does not have to be punched from bubble-packed cards so as to correspond with the current date; rather, the first dose used from a card should be punched from bubble #30, the second dose from bubble #29, etc.).

Example:

LOCATION NO.	NAME OF FACILITY	ADMISSION NO.	PATIENT NAME	MEDICATION RECORD AND PROFILE
	ALF		Smith, Anna	

TREATMENT	How	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
STAFF TO ASSIST WITH MEDICATIONS																																
****ORR YES****																																
7-13-95	P													KB						TS	TS											
TYLENOL 325 mg.	R																															
2 TAB FOR HEADACHE PAIN / FEVER	N																															
(NOTE: MAY TAKE 1-2 DOESES IN 24 HOURS, IF NEEDS MORE OFTEN CONTACT RN)																																

Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature
1 KB	Kathy Baker	4		7		10	
2 TS	Teresa Smith	5		8		11	
3		6		9		12 JS	Jane Smith, RN

PRIMARY PHYSICIAN		ALTERNATIVE PHYSICIAN		Allergies
Dr. Bill Jones	555-0343	MD on Call		

PATIENT'S NAME	Admission Date	Room	Bed	Age	Sex	Med Rec. No.	Pulse	Blood Pressure	Height	Weight	Date	Page
Anna Smith	12-1-95	101		90	F		72	130/91	5'2"	99	July 1, 1995	01

- On the back of the medication record, write the date, time, medication, strength, number of tablets given, and the reason the PRN medication was given.

Example:

NURSE'S MEDICATION NOTES

DATE	HOUR	Initials	MEDICATION	REASON	HOUR	Initials	RESULT
7-18-95	10am	KB	Tylenol # 3	Headache	1130pm	KB	
7-19-95	9pm	TS	Tylenol # 3	Headache	10pm	TS	
7-20-95	4pm	TS	Tylenol # 3	Headache	5pm	TS	

INSTRUCTIONS

1. INITIAL APPROPRIATE BOX ON FORNT WHEN MEDICATION GIVEN.
2. CIRCLE INITIAL WHEN MEDICATION REFUSED OR HELD AND STATE REASON.
3. STATE REASON AND RESULT FROM PRN MEDICATION.
4. INDICATE SITE OF INJECTION WITH APPROPRIATE CODE.

INJECTION SITE CODE

1. BUTTOCK (GLUTEUS) LEFT
2. BUTTOCK (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH QUADRICEPS) RIGHT
7. ILIAC CREST LEFT
8. ILIAC CREST RIGHT
9. OTHER (SPECIFY

PATIENT: | MEDICAL RECORD NO. | PHYSICIAN:

- Hand the medication cup to the tenant. Be sure to observe the tenant taking the medication (i.e., do not leave the medication with him/her to take at a later time).

- Initial on the tenant's medication record in the square for the appropriate assistance time for the medication, in the column for the current day.

4. ***If a multi-dose packaging system is used, the staff member should:***

- Follow the instructions in #2above (i.e., comparing the information in the medication book with that on the label).

- Initial on the tenant's medication record in the square for the appropriate assistance time for the medication in the column for the current day.

- On the back of the medication record, write the date, time, medication, strength, number of tablets given, and the reason the PRN medication was given. Then initial in the "Initials" column.

- Have the tenant remove the medication from the container if he/she is able (PRN medications are packaged in separate containers when using a multi-dose packaging system).

- If the tenant is not able to do this, assist the tenant as needed in removing the medication from the container.

- Observe the tenant taking the medication (do not leave the medication with the tenant).

5. If a tenant refuses a medication, offer it again later in the shift as appropriate. If the medication is not taken within an appropriate time frame, follow the procedures in the "Refused Medications" section of this manual. If unsure of the appropriate window of time in which a medication may be re-offered, call the RN.

6. One to two hours after giving a PRN medication, write on the back of the medication record the results of the medication (e.g., tenant sleeping, headache better, etc.).

Example:

NURSE'S MEDICATION NOTES

DATE	HOUR	Initials	MEDICATION	REASON	HOUR	Initials	RESULT
7-8-95	10am	KB	Tylenol # 3	Headache	1130pm	KB	Headache gone
7-9-95	9pm	TS	Tylenol # 3	Headache	10pm	TS	Headache gone
7-20-95	4pm	TS	Tylenol # 3	Headache	5pm	TS	Head still hurts called nurse. Will monitor until AM

INSTRUCTIONS

1. INITIAL APPROPRIATE BOX ON FORNT WHEN MEDICATION GIVEN.
2. CIRCLE INITIAL WHEN MEDICATION REFUSED OR HELD AND STATE REASON.
3. STATE REASON AND RESULT FROM PRN MEDICATION.
4. INDICATE SITE OF INJECTION WITH APPROPRIATE CODE.

INJECTION SITE CODE

1. BUTTOCK (GLUTEUS) LEFT
2. BUTTOCK (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH QUADRICEPS) RIGHT
7. ILIAC CREST LEFT
8. ILIAC CREST RIGHT
9. OTHER (SPECIFY

PATIENT: MEDICAL RECORD NO. PHYSICIAN:

7. If additional action is needed based on the tenant's condition, contact the RN.

ASSISTING WITH CONTROLLED MEDICATIONS

POLICY: Follow established procedures for the storage of and assistance with controlled medications.

PROCEDURES:

1. Medication containers for all narcotic or controlled medications must be marked with a "C" on the label to indicate that the medication is a "controlled substance." These medications are differentiated in this manner as special procedures must be followed for controlled substances.

2. For every medication that is marked with a "C" on the label, a Narcotic Inventory (or Count) Sheet should be maintained. These forms are located in the medication room in the filing box.

3. When a controlled medication is received from the pharmacy (or the tenant at the time of move-in), the RN (or other designated staff person) should count the number of tablets/capsules and enter this number on the Narcotic Inventory Sheet in the "Amount Received" column. The date, time, and signature of the person should also be entered on this form.

Example:

NARCOTIC INVENTORY SHEET

Tenant Name:	SMITH, ANNA	Medication Name:	TYLENOL #3
Date Received:	07-02-95	Dosage:	PRN EVERY 4 HRS. AS NEEDED
Physician's Name:	DR. BILL JONES	Rx Number:	07-02-92-480

DATE	TIME	AMOUNT ON HAND	AMOUNT GIVEN	AMOUNT RECEIVED	AMOUNT REMAINING	STAFF SIGNATURE
				30		J. Smith, RN

Narcotic Inventory Sheet FM-PC201

4. Maintain Narcotic Inventory Sheets with the tenant's current medication record.

5. When assisting a tenant in taking a controlled medication, a staff member should:

   - Turn to the Narcotic Inventory Sheet with identifying information that corresponds to the label on the medication container. Write in the date, time and signature on the next blank line on the Narcotic Inventory Sheet (NEVER leave a blank line on the form).
   - Count the number of tablets/capsules available (e.g., in a bubble-packed card) and enter that number in the "Amount on Hand" column on the form.
   - Draw a line through the "Amount Received" column.
   - Write the number of tablets/capsules to be given at the designated time in the "Amount Given" column.
   - Subtract the number of tablets/capsules written in the "Amount Given" column from the number in the "Amount on Hand" column. Write the resulting number in the "Amount Remaining" column (this should be the number of tablets/capsules left after the current dose is taken).

Example:

NARCOTIC INVENTORY SHEET

Tenant Name: SMITH, ANNA Medication Name: TYLENOL #3

Date Received: 07-02-95 Dosage: PRN EVERY 4 HRS. AS NEEDED

Physician's Name: DR. BILL JONES Rx Number: 07-02-92-480

DATE	TIME	AMOUNT ON HAND	AMOUNT GIVEN	AMOUNT RECEIVED	AMOUNT REMAINING	STAFF SIGNATURE
				30		J. Smith, RN
7-13-95	11:30pm	30	1		29	Kathy Baker
7-19-95	10:00pm	29	1		28	Terry Smith
7-20-95	5:00pm	28	1		27	Terry Smith

Narcotic Inventory Sheet FM-

- Follow all procedures in the sections on "Assisting with Routine Medications" or "Assisting with PRN Medications" in this manual.

6. On a regularly scheduled basis, the number of each controlled medication on hand must be counted by two staff members together, with this number compared to the last number in the "Amount Remaining" column on the Narcotic Inventory Sheet.

7. If a discrepancy is discovered between the "Amount Remaining" number on a Narcotic Inventory Sheet and the number of tablets/capsules actually on hand, staff should:

   - Re-count the number of tablets/capsules actually on hand, and again compare this number to the "Amount Remaining" on the Narcotic Inventory Sheet.

   - Determine from the appropriate medication record when the medication was last given and if documentation was made on the Narcotic Inventory Sheet.

8. If these measures do not resolve the discrepancy, notify the RN or Administrator. Neither staff member involved in the count should leave the building until the reason for the discrepancy has been identified or they have been granted permission to leave by the RN or Administrator.

9. If the count is not resolved (i.e., the missing narcotic(s) have not been accounted for):

   - The RN or Administrator should conduct another count of all controlled substances, comparing this count with the "Amount Remaining" number on each Narcotic Inventory Sheet.

   - If the repeat count verifies that the medications are missing, the police, pharmacy, and/or State licensing agency may need to be called.

   - Complete a Medication Error Incident Report form (see the section in this manual on Medication Error Incident Reports).

   - The RN and/or Administrator should conduct an investigation by interviewing all staff who may have had access to the narcotics after the last correct count was taken. These employees may either give a written or verbal statement regarding their knowledge of the incident.

   - The Administrator or RN should maintain a record of all steps taken to account for the missing narcotic. Keep this record, along with all verbal and written statements obtained, in an investigation file that should be kept in a file cabinet in the Administrator's office.

   - If the reason for the missing narcotics is determined, take appropriate disciplinary action (see the section in the Personnel Policy and Procedure manual on Disciplinary Action).

10. If a tenant who has narcotic medications plans to be away from the building during a time period(s) when he/she would be assisted with the medication, staff must follow special procedures in releasing the medication to the tenant (see the section in this manual on "Out-of-Building Medications"). In such a situation the tenant or the person who will be responsible for the tenant's medications while he/she is away from the building must sign for release of the medications on the Narcotic Inventory Sheet for each medication.

REFUSED MEDICATIONS

POLICY: When a tenant refuses a medication, document the refusal in the tenant's medication record with notification to all appropriate parties made.

PROCEDURES

1. When a tenant refuses medication or treatment, initial on the tenant's medication record in the corresponding square for that order on the appropriate date and circle your initials.

Example:

LOCATION NO.	NAME OF FACILITY	ADMISSION NO.	PATIENT NAME	MEDICATION RECORD AND PROFILE
	ALF		JANE DOE	

TREATMENT	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
STAFF SHALL ASSIST WITH MEDICATION																																
******CPR NO******																																
2/4/1996	8AM				KB	KB	KB	JF	JF	JF	JF	KB	KB	KB	KB	JF	JF	JF	JF													
DILANTIN 100 mg. 1 TAB BY MOUTH 2X DAY FOR SEIZURES	8PM				ML	ML	ML	TS	TS	TS	TS	TS	ML	ML	ML	ML	TS	TS	TS												

Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature	Initials	Staff Signature
1 KB	Kathy BAtes	4 TS	Theresa Smith	7		10	
2 JF	JulieFord	5		8		11	
3 ML	Mary Lyons	6		9		12 JS	Janis Smith, RN

PRIMARY PHYSICIAN	ALTERNATIVE PHYSICIAN	Allergies
John Smith		

PATIENT'S NAME	Admission Date	Room	Bed	Age	Sex	Med Rec. No.	Pulse	Blood Pressure	Height	Weight	Date	Page

2. On the back of the medication record write the date, time, medication name and dose (strength and quantity), and the reason the medication was not taken.

Example:

NURSE'S MEDICATION NOTES

DATE	HOUR	Initials	MEDICATION	REASON	HOUR	Initials	RESULT
5-10-95	8 am	JF	Dilantin 100 mg.	Refused, RN/MD notified	8 am	JF	Observed during day–no result
5-16-95	8 pm	TS	Dilantin 100 mg.	Refused. Said makes ill. RN/MD			
				notified	8 pm	TS	Dr. visit scheduled 5-17-95

INSTRUCTIONS

1. INITIAL APPROPRIATE BOX ON FORNT WHEN MEDICATION GIVEN.
2. CIRCLE INITIAL WHEN MEDICATION REFUSED OR HELD AND STATE REASON.
3. STATE REASON AND RESULT FROM PRN MEDICATION.
4. INDICATE SITE OF INJECTION WITH APPROPRIATE CODE.

INJECTION SITE CODE

1. BUTTOCK (GLUTEUS) LEFT
2. BUTTOCK (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH QUADRICEPS) RIGHT
7. ILIAC CREST LEFT
8. ILIAC CREST RIGHT
9. OTHER (SPECIFY

PATIENT: MEDICAL RECORD NO. PHYSICIAN:

3. Notify the RN the first time a tenant refuses a medication for appropriate instructions to staff if any follow-up is needed. As appropriate, the RN may then include parameters with the medication instructions on the medication record as to whom, if anyone, to notify upon future refusals of the medication by the tenant and/or what actions the staff should take.

4. Dispose the refused medication according to those procedures outlined in the section in this manual on "Disposal of Medications."

5. If a tenant refuses a medication on a consistent basis, the RN or Administrator should ask him/her the reason for the refusals. The RN or Administrator should then try to address the tenant's concern. If appropriate, the RN should contact the tenant's physician and/or pharmacist to determine any viable alternatives to the current order that might be more acceptable to the tenant.

"OUT OF BUILDING" MEDICATIONS

POLICY: Staff shall release medications for tenant use according to established procedures to tenants and/or their responsible parties when tenants plan to be absent from the Community.

PROCEDURES:

1. If staff are providing a tenant with medication assistance, follow the procedures listed below if the tenant plans to be out of the building when medication assistance would be provided:

When a Bubble-Packed System is Used:

2. Staff should prepare an out-of-building medication envelope for each medication dose the tenant will miss (e.g., if he/she will miss his/her 8:00 am and 12:00 medications, two envelopes should be prepared).

3. On each envelope, the staff member should write the time and date the medication is to be taken, the tenant's name, the physician's name, and instructions for the medication (including dose, strength, and how to take). Complete a separate envelope for each medication.

4. If a tenant who receives assistance with medications plans to be away from the building for an extended period of time, the tenant's bubble-packed cards should be sent with the tenant and/or the person who will be responsible for the tenant's medications.

5. **IF THE TENANT HAS NARCOTIC MEDICATIONS**, these cards should not leave the building. Rather, follow these procedures:

   - If the tenant will be gone from the Community for less than three days, place the appropriate medications in out-of-building envelope(s), as per the instructions outlined above. In addition, however, the tenant or responsible party must sign the Narcotic Inventory sheet for each narcotic taken from the building (see the procedures in this manual for Assistance with Controlled Medications).

   - If the tenant will be absent from the Community for a period longer than three days, the RN or Administrator should consult with the pharmacist regarding possible alternatives for supplying the tenant with his/her medications. Alternatives may include having the medications repackaged so the tenant can take only the medications that will be needed during his/her absence or obtaining a new medication order from the tenant's physician for this period of time.

If Using a Multi-Dose Packaging System:

6. If a multi-dose system is used, determine which labeled medication packages correspond to the times and dates the tenant will be away from the building. Give these packages to the tenant or the person who will be responsible for the tenant's medications and explain what medications should be taken when. Ask that any unused medications be returned to the Community.

7. If the tenant has any narcotic medications, the tenant or person who will be responsible for his/her medications must sign for the release of the medications on the Narcotic Inventory Sheet corresponding to each medication.

For All Out-of-Building Medications:

8. When releasing a tenant's medications to a tenant and/or responsible party, the RN, Administrator, or other designated staff member should document the release on the back of the tenant's medication record:

   - Note the date, time, medication (name, strength and quantity released) in the appropriate spaces.

   - Initial in the "Initials" column

- In the "Reason" column, state "Medications sent with tenant and/or family member."

9. At each medication assistance time that the tenant is away from the building:

   - Make a line with each day tenant is gone from facility then when tenant returns continue initialing each medication as previously stated.

10. The refusal should then be recorded on the back of the medication sheet by noting the day, time, "medication refused while tenant out of building", and the reason for the refusal if known.

11. Any refused medications returned to the building should be disposed of according to the procedures in the section on "Disposal of Medications" in this manual.

DISPOSAL OF MEDICATIONS

POLICY: Medications shall be disposed of according to state and federal regulations and established procedure, with appropriate documentation made.

PROCEDURES:

1. Medication must be disposed of when it is refused by a tenant, becomes outdated (i.e., expired), or is discontinued by the tenant's physician. Depending upon the situation, destroy the medication at the Community or return it to the pharmacy.

2. Check expiration dates for all medications (prescription and over-the-counter) on a regular basis to ensure that all medications are current.

3. Dispose of a single dose of medication (e.g., a medication that was refused by a tenant) by placing the medication in a medication disposal container (typically supplied by the company supplying the Community's sharps containers).

4. If disposing larger quantities of medications (e.g., due to a change in order, discontinued order, or the death of a tenant), the medications should be returned to the issuing pharmacy. The House pharmacy may have a policy that any unused bubble-packed medications and unopened tubes/bottles of medications supplied by the House pharmacy may be returned with credit provided to the tenant.

5. Typically, controlled medications (i.e., those marked with a "C") cannot be returned to the pharmacy. Thus, when these medications need to be destroyed, they must be placed in a medication disposal container, with those procedures outlined in #3 and above followed.

6. Document the disposal on a Narcotic Inventory Sheet, with the date, time, amount and method of disposal noted. Only licensed personnel staff are allowed to destroy any controlled medication.

7. Dispose of medications as soon as possible after the need for disposal has been determined (e.g., the tenant refuses a medication, a medication has expired, an order has been discontinued, etc.).

MEDICATION ERRORS

POLICY: Report any medication error to the RN (and other parties as appropriate), with appropriate follow-up action taken and documentation made.

PROCEDURES:

1. A medication error may be defined as any one of the following:

   - Wrong Dose – any medication given at a dose not ordered by the physician
   - Missed Dose – Any dose of medication that is not administered
   - Extra Dose – Any dose of medication given in excess of the number of daily doses ordered by the physician.
   - Wrong Route – Any dose of medication administered by a different route than that ordered by the physician.
   - Wrong Tenant – Any dose of medication administered to the wrong tenant.
   - Wrong Time – Any dose of medication administered more than one hour before or after the designated time of administration as ordered by the physician (i.e., as written in the medication book).
   - Missing Medication – Any medication that cannot be accounted for.
   - Given after the "D/C" Date – Any medication given after it has been discontinued by the physician.
   - Given with No Order – Any medication given without a physician's order

2. When any of these errors occur, notify the RN immediately. Follow all instructions provided by the RN.

3. The staff member involved in the medication error should complete a Medication Error Incident Report.

   - On a Medication Error Incident Report form, describe the incident, note all action taken, and sign the form. Under the "Action Taken" part of the form, document all individuals contacted regarding the incident (e.g., physician, family, licensing agency, etc.).

- The RN and Administrator should note any additional action needed. Develop a plan to prevent recurrence of the incident. Both the RN and Administrator should review and sign the Medication Error Incident Report form.

4. Document the original incident and all follow-up action taken in the tenant's Service Notes (this can be a summary of the incident with a reference to the Medication Error Incident Report).

5. Provide appropriate follow-up and training to the staff person who made the medication error (with disciplinary action taken if needed). Document all action taken in the employee's Personnel Notes.

Prime Living Dietary Information

Regular Diets: **General Diet with no restrictions.**
Meet nutritional needs based on Dietary Reference intakes (DRI).
Calories: 1800-2300 per day
Total Fat < 35% daily calories
Sodium: < 3000mg
Protein: 80-120 g

Purpose: Regular diet is designed to meet the nutritional needs of individuals who are not acutely ill and do not require mechanical modifications or dietary restrictions. This diet is based on the DRI, 2010 Dietary Guidelines for Americans and *Choose My Plate* provides a variety of foods and the appropriate number of servings of the food groups on a daily basis. This diet also incorporates the basic principles of nutrition and healthy eating.

Quick-Reference to *Choose My Plate* (Based on a 2000 Calorie Diet):

Breads: 6 ounces total daily
1 ounces = 1 slice of bread, 1 oz dry cereal, ½ cup cooked cereal, ½ cup cooked rice/pasta. This includes muffins, sweet breads, and potatoes (white or sweet)

Fruits: 2 cups
½ cup = 1 medium piece of fresh fruit, ½ cup chopped, cooked or canned fruit, ½ cup 100% fruit juice.

Dairy: 3 cups
1 cup = 1 cup milk or yogurt, 1-2 ounces cheese

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½ cup = 1 medium piece of fresh fruit, ½ cup chopped, cooked or canned fruit, ½ cup 100% fruit juice.

Dairy: 3 cups
1 cup = 1 cup milk or yogurt, 1-2 ounces cheese

Protein: 5 ½ ounces
1 ounce = 1 ounce cooked lean meat, poultry, or fish; ¼ cup cooked beans; 1 egg; 1Tablespoon Peanut Butter.

Vegetables: 2 ½ cups
1 serving = 1 cup raw leafy greens, ½ cup raw or cooked vegetables, ½ cup vegetable juice.

Discretionary Calories such as fats and sweets, use sparingly

6 ounces of bread daily 4 ounces of bread
2 ounces each meal

2 cups of fruit 1 1/3 cup of fruit

¾ cup each meal

3 cups of dairy 2 cups of dairy

1 cup dairy each meal

5 ½ ounces of protein 4 ounces of protein

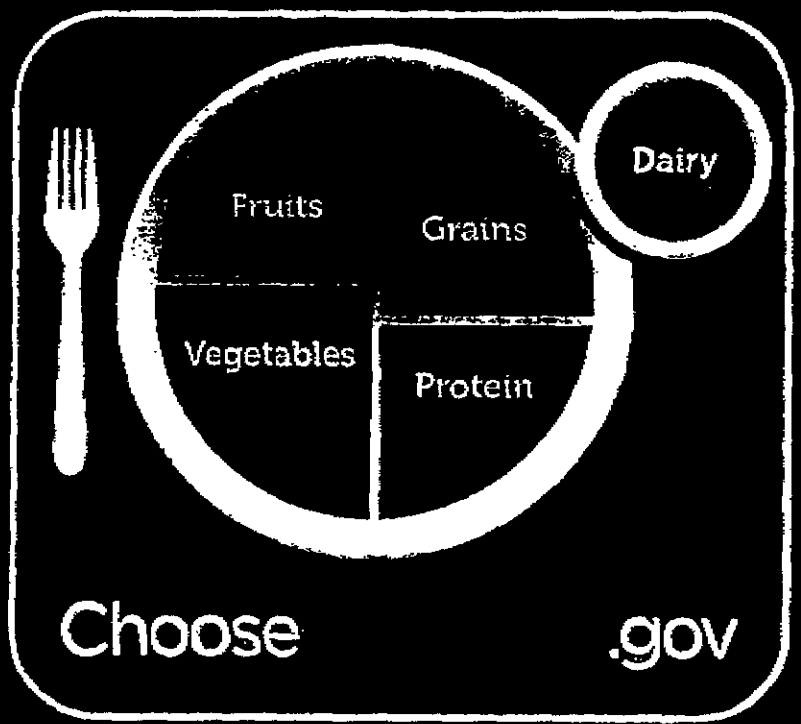
2 ounces protein each meal

2 ½ cups vegetables 1 2/3 cups vegetable

¾ cup each meal

Prime offers 2/3 of the above Monday – Friday & 1/3 on Saturday and Sunday....numbers in red identify amounts necessary to serve per meal

What's on your plate?



Make half your *plate fruits and* vegetables.

Make at least *half your grains* whole.

Switch to skim or 1% milk.

Vary your protein food choices.

[illegible]	Fruits	Grains	[illegible]	Protein Foods
Eat more red, orange, and dark-green veggies like tomatoes, sweet potatoes, and broccoli in main dishes. Add beans or peas to salads (kidney or chickpeas), soups (split peas or lentils), and side dishes (pinto or baked beans), or serve as a main dish. Fresh, frozen, and canned vegetables all count. Choose "reduced sodium" or "no-salt-added" canned veggies.	Use fruits as snacks, salads, and desserts. At breakfast, top your cereal with bananas or strawberries; add blueberries to pancakes. Buy fruits that are dried, frozen, and canned (in water or 100% juice), as well as fresh fruits. Select 100% fruit juice when choosing juices.	Substitute whole-grain choices for refined-grain breads, bagels, rolls, breakfast cereals, crackers, rice, and pasta. Check the ingredients list on product labels for the words "whole" or "whole grain" before the grain ingredient name. Choose products that name a whole grain first on the ingredients list.	Choose skim (fat-free) or 1% (low-fat) milk. They have the same amount of calcium and other essential nutrients as whole milk, but less fat and calories. Top fruit salads and baked potatoes with low-fat yogurt. If you are lactose intolerant, try lactose-free milk or fortified soymilk (soy beverage).	Eat a variety of foods from the protein food group each week, such as seafood, beans and peas, and nuts as well as lean meats, poultry, and eggs. Twice a week, make seafood the protein on your plate. Choose lean meats and ground beef that are at least 90% lean. Trim or drain fat from meat and remove skin from poultry to cut fat and calories.
For a 2,000-calorie daily food plan, you need the amounts below from each food group. To find amounts personalized for you, go to ChooseMyPlate.gov				
Eat 2½ cups every day **What counts as a cup?** 1 cup of raw or cooked vegetables or vegetable juice; 2 cups of leafy salad greens	**Eat 2 cups every day** **What counts as a cup?** 1 cup of raw or cooked fruit or 100% fruit juice; ½ cup dried fruit	**Eat 6 ounces every day** **What counts as an ounce?** 1 slice of bread; ½ cup of cooked rice, cereal, or pasta; 1 ounce of ready-to-eat cereal	**Get 3 cups every day** **What counts as a cup?** 1 cup of milk, yogurt, or fortified soymilk; 1½ ounces natural or 2 ounces processed cheese	**Eat 5½ ounces every day** **What counts as an ounce?** 1 ounce of lean meat, poultry, or fish; 1 egg; 1 Tbsp peanut butter; ½ ounce nuts or seeds; ¼ cup beans or peas

[illegible]

[illegible]

Look out for salt (sodium) in foods you buy. Compare sodium in foods and choose those with a lower number.

Drink water instead of sugary drinks. Eat sugary desserts less often.

Make foods that are high in solid fats—such as cakes, cookies, ice cream, pizza, cheese, sausages, and hot dogs—occasional choices, not every day foods.

Limit empty calories to less than 260 per day, based on a 2,000 calorie diet.

[illegible]

Pick activities you like and do each for at least 10 minutes at a time. Every bit adds up, and health benefits increase as you spend more time being active.

Children and adolescents: get 60 minutes or more a day.

Adults: get 2 hours and 30 minutes or more a week of activity that requires moderate effort, such as brisk walking.

January Lunch Menu

Sun	Mon	Tue	Wed	Thu	Fri	Sat
Prime will offer 6 ounce serving of juice and milk with each meal				1 Egg Bake Casserole Bacon Muffin	2 Tuna Casserole Peas Dinner roll Cookies	3 Tavern Pickle Chips Fruit
4 BBQ Chicken Boiled Potatoes Veggies Cake	5 Pork Casserole Carrots Dessert Bar	6 Roast Beef Mashed Potatoes/Gravy Veggies Jello	7 Ham & Baked Squash Veggies Fruit	8 Chef Salad Bread Sticks Cookies	9 Pork Cutlets Potatoes Veggies Dessert	10 Goulash Salad Dinner Roll Ice Cream
11 Hamburger Steak w/Onion & Mushrooms Baked Potato Fruit	12 Philly sandwiches Pickle Coleslaw cookie	13 Meatloaf Mashed Potatoes/Gravy Veggies Fruit	14 Chicken Strips French Fries Corn Pie	15 Tater Tot Casserole Salad Desert Bar	16 Lasagna Salad Garlic Bread Fruit	17 Scalloped Potatoes & Ham Veggies Fruit
18 Pork roast Baked potato Veggies Lemon bars	19 Fish on a Bun Tater Tots Veggies Cookies	20 Meatballs Parsley Potatoes Salad Pudding	21 Enchilada Casserole Salad Jello	22 Chicken Noodle Casserole Dessert Bar	23 Pancakes Sausage Fruit	24 Pizza Bake Salad Fruit
25 Baked Chicken Potatoes Veggies Pie	26 Hot Turkey Sandwich Green beans Peach crisp	27 Chef Salad Bread Sticks Dessert Bar	28 Hot Dogs Potato Salad Cake	29 Soft Shell Taco Chips & Salsa Ice Cream	30 Beef Stroganoff Vegetable Cake	31 Spaghetti & Meat Sauce Salad Pudding

January Supper Menu

Sun	Mon	Tue	Wed	Thu	Fri	Sat
Prime will offer 6 ounces of milk and juice with every meal				1 Sub Sandwich Chips Dessert Bar	2 Roast Beef Sandwich Cole Slaw Cookies	3
4	5 Grilled Cheese Tomato Soup Fruit	6 Egg Salad Sandwich Cucumbers & Onions Dessert Bar	7 Ham & Swiss Cheese Sandwich Vegetable Salad Brownie	8 Tuna Salad Sandwich Chips Fresh Fruit	9 Pulled Pork Sandwich Baked Beans Ice Cream	10
11	12 Lasagna Soup Bread stick Chocolate Pudding Surprise	13 Turkey Sandwich Pea Salad Fruited Jello	14 Pizza Burgers Salad Blushing Pears	15 Cream Chipped Beef on Toast Peas Fruit	16 Grilled Ham & Cheese French Fries Dessert Bar	17
18	19 Chicken Nuggets Mashed Potatoes/Gravy Green Beans Jello Cake	20 Cheese Burgers Lettuce/tomato Fries Ice Cream	21 Ham Salad Sandwich Tomato Slices Cupcakes	22 Chili Cheese & Crackers Cinnamon Roll	23 Brats on a Bun Baked Beans Chips Peaches	24
25	26 Rueben's French Fries Ice Cream	27 Sloppy Joe's Chips Watermelon	28 Bacon/ Cheeseburger Casserole Jello Cake	29 Chicken Salad Sandwich Fruit Salad Pudding	30 BLT Sandwich Macaroni Salad Fruit	31