IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
59479-I
60347-I
60369-I
60345-C

July 1, 2016

Ms. Dara Fishnick, Director
Oak Park Place
1381 Oak Park Place
Dubuque, IA 52002

RE: Final Complaint/Incident Investigation Report, Oak Park Place, Dubuque, Iowa

Dear Ms. Fishnick:

Enclosed is the **Final Complaint/Incident Investigation Report** completed 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 **June 9 - 20, 2016.**

Investigations of Incidents #59479-I, #60347-I, #60369-I and Complaint #60345-C were completed. There were no regulatory insufficiencies identified related to Incidents #59479-I, #60347-I and Complaint #60345-C.

The following allegation was investigated in regards to Incident #59479-I:

1. Allegation: Tenant Rights
   Findings: Unsubstantiated
   Comments: Review of a tenant file, staff files, staff interviews and review of Program documents did not reveal concerns regarding tenant rights.

The following allegation was investigated in regards to Incident #60347-I:

1. Allegation: Tenant Rights
   Findings: Unsubstantiated
   Comments: Review of a tenant file, staff files, staff interviews and review of Program documents did not reveal concerns regarding tenant rights.

The following allegation was investigated in regards to Complaint #60345-C:

1. Allegation: Tenant Rights
   Findings: Unsubstantiated
   Comments: Review of tenant files, staff files, staff interviews and review of Program documents did not reveal concerns regarding tenant rights.

There were regulatory insufficiencies identified related to Incident #60369-I and during the course of the investigation. The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Medications and Tenant Documents.

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.

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. Please refer to rule 67.14 for more information.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Linda Kellen, Bureau Chief
Adult Services/Special Services

Rose Boccella

Rose Boccella, Program Coordinator
Adult Services Bureau

Enclosure

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
	S0218	A. BUILDING: _____ B. WING _____	C 06/20/2016

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OAK PARK PLACE	1381 OAK PARK PLACE DUBUQUE, IA 52002

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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 Number of tenants without cognitive disorder: 37 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 38 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 18 Total Population of Program at time of on-site: 19 TOTAL census of Assisted Living Program: 57 Investigations of Incident #59479-I, Incident #60347-I, Incident #60369-I and Complaint #60345-C were completed. There were no regulatory insufficiencies identified related to Incident #59479-I, Incident #60347-I and Complaint #60345-C. There were regulatory insufficiencies identified related to Incident #60369-I and during the course of the investigation.	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	A 003		

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A 003	Continued From page 1 including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents, the Program failed to follow their policy and procedure related to narcotic count for one of four tenant files reviewed (Tenant #3). Staff did not count narcotics according to policy and procedure for Tenant #3 and there were five unaccounted syringes of Lorazepam for Tenant #3. (Incident #60369-I) 1. Tenant #3, an 86 year old, was admitted on 5-3-14 and had a diagnosis of: Alzheimer's dementia. Tenant #3 was staged at a seven on the Global Deterioration Scale, which indicated very severe cognitive decline. Tenant #3 received Hospice services. Tenant #3 resided in a dementia unit and died on 6-5-16. According to Tenant #'3's service plan, staff/Hospice would be responsible for ordering and storing all medications in a locked medication cart/refrigerator. Staff/Hospice would administer medications per doctor order and nurse delegations. 2. According to a Physician's Telephone Order dated 9-10-15, Lorazepam 0.5 milligrams (mg) by mouth, every four hours, as needed, was ordered (change to liquid medication). According to controlled medication record on 3-9-16, 30 milliliters (ml) of Lorazepam Intensol 2 mg/ml was received. The dose was 0.25 ml (0.5 mg) and directions indicated to take 0.25 ml (0.5 mg) by	A 003		

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A 003	Continued From page 2	A 003		

mouth four every hours as needed. From 3-10-16 to 5-30-16 at 4:00 p.m. staff documented Lorazepam 0.25 ml was administered as needed.

According to a Hospice document, on 5-28-16 Lorazepam 0.5 mg 2 mg/ml (0.25 ml) was ordered every four hours and every one hour as needed for restlessness/shortness of breath (SOB).

3. According to a Program document, on 5-30-16 the registered nurse (RN) filled 25 syringes of Lorazepam for Tenant #3 and showed them to Staff B, locked them up and documented 25 syringes on the controlled medication sheet. Staff B documented three doses given and each time documented one less syringe on the controlled medication sheet. At 6:00 a.m. on 5-31-16 Staff B and Staff A counted and documented 22 syringes of Lorazepam. Staff A wrote 22 and Staff A and Staff B both initialed. Staff B said he took each syringe out of the bag and laid it on the counter/table. Staff B said Staff A watched as Staff B counted. Staff B said 22, Staff A wrote 22 on the controlled medication sheet and they both initialed. On 5-31-16 at 2:00 p.m. Staff A and Staff C counted the syringes of Lorazepam and there were 15 syringes. Staff A documented giving 2 syringes on her shift so there should have been 20 syringes and not 15 syringes. When interviewed Staff A said she "didn't really pay attention" when Staff B counted the syringes at 6:00 a.m.

4. According to a controlled medication record, on 5-30-16 the RN drew up 25 syringes of Lorazepam for staff to administer to Tenant #3. The dose was documented as 0.5 mg/0.125 ml and the instructions were to give one syringe every four hours and every one hour as needed

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A 003	Continued From page 3 (the prescribed dose was 0.5 mg/0.25 ml.) According to a controlled medication record, on 5-30-16 at 8:00 p.m. Staff B signed out one dose with 24 remaining. On 5-31-16 at 12:00 a.m. and 4:00 a.m. Staff B signed out doses with 23 and 22 remaining. On 5-31-16 at 8:00 a.m. and 12:00 p.m. Staff A signed out doses with 21 and 20 remaining. On 5-31-16 at 4:30 p.m. a new count was established with 15 syringes remaining. The count records did not indicate a count occurred between the RN and Staff B when the 25 syringes were drawn up. On 5-31-16 at shift change between third to first shift Staff B and Staff A indicated a count of 22 syringes and both staff signed. The next entry of counts between first and second shift had Staff A and Staff C's signatures; however, the count was not provided. Staff C had also signed the entry of the count from second to third shifts with no count provided. 5. According to the RN's statement on 5-30-16 she came to work as there was a change in orders from Hospice for Tenant #3. She started to draw up Lorazepam Intensol (new order) on a scheduled basis. The Lorazepam Intensol had previously been an as needed order and staff used an enclosed eye dropper for doses. She drew up what the order required 0.5 mg/0.125 ml into 25 syringes labeled appropriately. Staff B came into the dementia unit nurse's office and she placed the syringes into groups of five and had five groups. She said to Staff B that she had five groups of five syringes each so Staff B could start administering the syringes with the 8:00 p.m. dose for Tenant #3. The syringes were gathered and placed into a bag labeled Lorazepam 0.5 mg/0.125 ml with Tenant #3's name. 6. According to an interview with Staff B, the RN filled Lorazepam in syringes for Tenant #3. Staff	A 003		

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A 003	Continued From page 4 B did not count the syringes with the RN. Staff B administered Lorazepam to Tenant #3 at 12:00 a.m. and 4:00 a.m. and subtracted on the MAR and controlled medication record and did not count. At 6:00 a.m. Staff B counted medications with Staff A and pulled them all out of the bag. Staff A and Staff B agreed on the count and keys were exchanged. According to Staff B's statement dated 5-31-16, last night Staff B mentioned to the RN that staff did not have syringes filled with Lorazepam and staff was taking it out of the bottle. The RN filled syringes of Lorazepam and put them in the refrigerator. Staff B did not count the number of syringes in the bag at that time. At 12:00 a.m. Staff B took one Morphine syringe and one Lorazepam syringe and put the bags back in the refrigerator. Staff B checked the medication administration records (MARs) once more for identification and went to Tenant #3's apartment. Staff B re-checked the syringes labeling to ensure they were correct. Staff B administered the medication to Tenant #3, initialed the MARs and put the number in the MARs, subtracted one from the total. The same was done in the controlled medication record. The same procedure was completed at 4:00 a.m. At 6:00 a.m. Staff B counted with Staff A. The bag of Lorazepam syringes were a "mess" so Staff B counted each one individually, one by one. Staff B told Staff A the number as Staff A had the controlled medication record. Staff A recorded the number as Staff B stated. Staff B then put each syringe in the bag and put them back in the refrigerator and locked it. 7. According to an interview with Staff A, she counted medications with Staff B that morning. Staff B brought the bag out (Lorazepam) and	A 003		

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A 003	Continued From page 5 Staff A was looking down at the book and took her eyes off of Staff B. Staff A did not watch Staff B count every syringe at the time of the count. Staff A administered two syringes of Morphine and Lorazepam on her shift and did not count the syringes at the time of administration. Staff A subtracted the syringes. Staff A counted the syringes with Staff C (at shift change). There were 15 syringes of Lorazepam and the controlled medication record indicated there should have been 20. According to Staff A's statement dated 5-31-16, on 5-31-16 at 6:15 a.m. Staff A counted medications with Staff B. Staff B said there were 23 syringes but Staff A did not watch Staff B "count all the way," and went off of the count of the MARs and the controlled medication records and did not count the syringes. Staff A gave two Lorazepam syringes, one at 8:00 a.m. and one at 12:00 p.m. When Staff A counted medications with Staff C there were only 15 syringes. Staff A checked the garbage and pulled four syringes (two Morphine and two Lorazepam). The MARs indicated there should have been 20 syringes. 8. According to an interview with the Director of Health Care Services, the RN reported Staff A and Staff C had completed a count and the count was off regarding Tenant #3's Lorazepam. The discrepancy was 5 syringes. The RN assured she had filled 25 syringes. Staff B verified a count was completed with Staff A (at shift change). When interviewed Staff A indicated she had not counted and had signed with the number Staff B said. Staff A said she had subtracted (regarding the count) and everyone did it. 9. According to an interview with the Director of Housing, the RN and Director of Health Care	A 003		

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A 003	Continued From page 6 Services reported there was a missing narcotic and the count was off. The RN filled 25 syringes of Lorazepam for Tenant #3. The RN was certain she set up 25 syringes. Staff B did not count the syringes with the RN and was told there were 25 syringes. Staff B said when Staff A and Staff B counted, Staff B counted the syringes and laid them out. Staff A wrote the number and Staff A watched. Staff A said Staff B counted and Staff A did not pay attention. Staff A stood next to Staff B while counting but did not know if the number was right and was not paying attention. 10. According to the Narcotic Count Procedure, it must be completed by two medication managers at each shift change, each medication manager must read the label on the bubblepack or bottle and the controlled medication record aloud. Both must match exactly. If the label and the directions on the controlled medication record did not match to contact administrative staff. Both medication managers were to be shoulder to shoulder and physically count the number of pills/syringes. Both medication managers should look at each bubblepack or pill sorter and see each pill/syringe being physically counted. The number on the controlled medication record should match the result of the pills counted. If a narcotic was given the medication manager should verify that it was signed out on the front of the controlled medication record and on the MAR with the count under initials on the MAR. At shift change the back of the controlled medication record should be updated with the correct number of narcotics and both medication managers signed indicating the count was correct. It indicated staff should not sign initials on the next line on the controlled medication record to save time.	A 003		

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A 147	Continued From page 7	A 147		
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, staff interviews and review of Program documents the Program failed to administer medications as prescribed by a doctor for one of four tenant files reviewed (Tenant #3). Tenant #3's order changed from Lorazepam 0.25 milliliter (ml) every four hours as needed to Lorazepam 0.25 ml every four hours and one hour as needed. Syringes were drawn up for staff to administer when the medication was administered on a scheduled basis. The Lorazepam dose drawn up in syringes was incorrect and multiple staff, on every shift, administered the incorrect dose 35 times to Tenant #3. Tenant #3's Lorazepam was not administered as prescribed by the doctor. (Incident #60369-I) 1. Tenant #3, an 86 year old, was admitted on 5-3-14 and had a diagnosis of: Alzheimer's dementia. Tenant #3 was staged at a seven on the Global Deterioration Scale, which indicated very severe cognitive decline. Tenant #3 received Hospice services. Tenant #3 resided in a	A 147		

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A 147	Continued From page 8 dementia unit and died on 6-5-16. According to the service plan, staff/Hospice would be responsible for ordering and storing all medications in a locked medication cart/refrigerator. Staff/Hospice would administer medications per doctor order and nurse delegations. 2. According to a Physician's Telephone Order dated 9-10-15, Lorazepam 0.5 milligrams (mg) by mouth every four hours as needed was ordered (change to liquid medication). According to controlled medication record on 3-9-16, 30 mililiters (ml) of Lorazepam Intensol 2 mg/ml was received. The dose was 0.25 ml (0.5 mg) and directions indicated to take 0.25 ml (0.5 mg) by mouth every four hours as needed. From 3-10-16 to 5-30-16 at 4:00 p.m. staff documented Lorazepam 0.25 ml was administered as needed. According to a Hospice document, on 5-28-16 Lorazepam 0.5 mg 2 mg/ml (0.25 ml) was ordered every four hours and every one hour as needed for restlessness/shortness of breath (SOB). According to a controlled medication record, on 5-30-16 the registered nurse (RN) drew up 25 syringes of Lorazepam for staff to administer to Tenant #3. The syringe dose was documented as 0.5 mg/0.125 ml and the instructions were to give one syringe every four hours and every one hour as needed for restlessness/SOB. From 5-30-16 at 8:00 p.m. to 6-3-16 at 12:00 a.m. 20 syringes of Lorazepam 0.125 ml were documented as administered to Tenant #3 despite the order for Lorazepam 0.25 ml. (There was a discrepancy of 5 syringes noted on 5-31-16, which were unaccounted for and reported to the Department).	A 147		

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A 147	Continued From page 9 According to a controlled medication record, on 6-2-16 the RN filled 12 syringes of Lorazepam for staff to administer to Tenant #3. The syringe dose was documented as 0.5 mg/0.125 ml and instructions were to give one syringe every four hours and every one hour as needed for restlessness/pain. According to a controlled medication record from 6-3-16 at 4:00 a.m. to 6-5-16 at 12:00 a.m. 12 syringes of Lorazepam at 0.125 ml were documented as administered to Tenant #3 despite the order for Lorazepam 0.25 ml. According to a controlled medication record, on 6-4-16 the RN filled 9 syringes of Lorazepam for staff to administer to Tenant #3. The dose was documented as 0.5 mg/0.125 ml and instructions were to give one syringe every four hours and every one hours as needed for restlessness/pain. According to a controlled medication record from 6-5-16 at 4:00 a.m. to 6-5-16 at 12:00 p.m. 3 syringes of Lorazepam 0.125 ml were documented as administered to Tenant #3 despite the order for Lorazepam 0.25 ml. According to a Program document, Tenant #3 died on 6-5-16 at 12:40 p.m. According to a controlled medication record on 6-5-16 at 1:30 p.m., 6 syringes were destroyed and documented by the RN and the Director Health Care Services. The dose recorded as destroyed in the remaining syringes was 0.125 ml. According to controlled medication records, from 5-30-16 to 6-4-16, 46 syringes were filled with Lorazepam 0.125 ml and not the prescribed amount of 0.25 ml. Of the 46 syringes, 6 were documented as destroyed after Tenant #3 died. There was also a reported discrepancy of 5 syringes, which left 35 syringes. According to	A 147		

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A 147	Continued From page 10	A 147		

controlled medication sheets 35 pre-filled syringes of 0.125 ml of Lorazepam were administered to Tenant #3 from 5-30-16 at 8:00 p.m. to 6-5-16 at 12:00 p.m.

3. Tenant #3's May 2016 MARs reflected Tenant #3's previous order of Lorazepam Intensol 2 mg/ml take 0.25 ml (0.5 mg) by mouth every four hours as needed. The order was not discontinued on the MAR when the new order was received on 5-28-16. On 5-30-16 the MAR reflected a new order for Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every four hours for restlessness/pain. The May 2016 MARs also reflected the order for the Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every one hour as needed for restlessness/pain.

Tenant #'3's June 2016 MARs reflected Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every four hours for restlessness/pain. The Lorazepam 0.5 mg every hour as needed was not reflected on the June 2016 MAR. Staff initialed on the May and June 2016 MARs for the administration of the Lorazepam at 0.25 ml despite the controlled medication sheets and syringes not matching the dose listed the MARs.

According to controlled medication records, from 5-30-16 to 6-5-16 the RN set up the syringes with the incorrect dose and 10 different staff administered the incorrect dose of Lorazepam on first, second and third shifts. On 6-5-16 when the medication syringes were destroyed the dose documented was Lorazepam 0.125 ml. The prescribed dose was Lorazepam 0.5 mg (0.25 ml). Tenant #3 received half of the prescribed dose of Lorazepam from 5-30-16 at 8:00 p.m. to the time of Tenant #3's death on 6-5-16. Tenant #3's Lorazepam was not administered according

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0218	A. BUILDING: _____ B. WING _____	C 06/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE	1381 OAK PARK PLACE DUBUQUE, IA 52002

(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 147	Continued From page 11 to doctor order. 4. According to an interview with the RN, on 5-30-16 she set up 25 syringes of Lorazepam 0.125 ml for Tenant #3. On 6-4-16 she set up 9 syringes of Lorazepam 0.125 ml for Tenant #3. According to the RN's statement on 5-30-16 she came to work as there was a change in orders from Hospice for Tenant #3. She started to draw up Lorazepam Intensol (new order) on a scheduled basis. The Lorazepam Intensol had previously been an as needed order and staff used an enclosed eye dropper for doses. She drew up what the order required 0.5 mg/0.125 ml into 25 syringes labeled appropriately. Staff B came into the dementia unit nurse's office and she placed the syringes into groups of five and had five groups. She said to Staff B that she had five groups of five syringes each so Staff B could start administering the syringes with the 8:00 p.m. dose for Tenant #3. The syringes were gathered and placed into a bag labeled Lorazepam 0.5 mg/0.125 ml with Tenant #3's name. 5. According to an interview with the Director of Health Care Services, from 5-30-16 until the time of Tenant #'3's death, the incorrect dose of Lorazepam was administered. Tenant #3 was ordered Lorazepam 0.25 ml and the syringes were set up (by the RN) with 0.125 ml. None of the staff, Hospice or Tenant #3's family voiced any concerns with Tenant #'3's comfort. None of the staff reported the syringes had an incorrect dose of Lorazepam. 6. According to the Program's policy and procedure regarding medications, when the Program was delegated to either administer or store medications the administration of	A 147		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 147	Continued From page 12 medications would be provided by a registered nurse or licensed practical nurse in Iowa or by delegated personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation.	A 147		
A 077	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant ' s medical record) This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, a staff interview and review of Program documents the Program failed to maintain tenant documents including an incident report for a medication error for one of four tenant files reviewed (Tenant #4). Tenant #4 did not receive doses of Coumadin as ordered and an incident report form was not completed related to the medication error. (During the course of the investigation) 1. Tenant #4, an 84 year old, was admitted on 6-12-14 and diagnoses included: history of neuropathy, diabetes, stroke, leg weakness secondary to spinal stenosis, cognitive decline, atrial fibrillation, right fractured ankle, sleep apnea and cholecystitis. The service plan indicated staff administered	A 077		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 077	Continued From page 13	A 077		

medications per doctor's orders. The service plan identified Tenant #4 took Coumadin and might have bruising of unknown origin and to notify the nurse if it occurred.

2. According to a Warfarin dose instructions document dated 5-6-16, 10 milligrams (mg) of Coumadin was ordered on Friday (5-6-16), 4 mg on Saturday (5-7-16) and Sunday (5-8-16). On Monday (5-9-16) 6 mg were ordered and a recheck was scheduled on Tuesday (5-10-16). The document was dated 5-6-16 and was noted on 5-9-16 at 1:15 p.m.

According to Interdisciplinary Progress Notes dated 5-10-16, Tenant #4 did not get Tenant #4's Coumadin dose on 5-8-16 and only received 6 mg on 5-6-16. The order was misplaced, according to the Interdisciplinary Progress Notes.

According to a Anticoagulant Therapy Flow Sheet, on 5-6-16 10 mg of Coumadin was ordered, then to resume 6 mg Monday and Friday and 4 mg all other days. On 5-9-16, the registered nurse (RN) called and reported Tenant #4 did not get the 10 mg dose of Coumadin on 5-6-16 and was given 6 mg instead. On 5-10-16 the document also indicated Tenant #4 also missed last nights dose and 10 mg was ordered for today and tomorrow.

According to the May 2016 medication administration records (MARs), Coumadin 4 mg take one tablet daily on Sunday, Tuesday, Wednesday, Thursday and Saturday was ordered. The MARs also reflected Coumadin 6 mg take one tablet by mouth daily on Monday and Friday. The medications were discontinued on the MAR dated 5-10-16. The new orders for Tenant #4's Coumadin were received on 5-6-16.

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 077	Continued From page 14 3. According to an interview with the RN, Tenant #4 missed a dose (Coumadin) and no had ill effect. 4. An incident report was not completed related to the medication error with Tenant #4's Coumadin. 5. According to the policy and procedure regarding events, any event or change that might significantly affect the health or well-being of a tenant must be reported promptly to assure tenant safety, supervision and timely and adequate treatment. If an unintended event occurred staff would first provide for the immediate safety of the tenant. When tenant safety was assured and the tenant had been transported to the emergency room or stabilized at the Program, staff would notify the nurse who would notify the Director of Housing, doctor, legal representative and any appropriate third party. Staff on duty at the time of the event would complete the top portion of the incident report. The nurse would complete the notification section of the incident report.	A 077		

July 8, 2016

Department of Inspections and Appeals
Attn: Rose Boccella
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Boccella:

On behalf of Oak Park Place, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Recertification and Complaint/Incident Investigation Report dated May July 1, 2016. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Iowa law. Oak Park Place will not request a formal hearing.

Policies and Procedures Related to Narcotic Count

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #3 no longer resides at Oak Park Place.

2. What measures will be taken to ensure the problem does not recur.
    - All staff responsible for administration of narcotic medications will be re-educated on Oak Park Place's policy and procedures for counting narcotics.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN Director or designee will audit the process of counting narcotics as least two times per year. This process will include staff observation of the task.

4. The date by which the regulatory insufficiency will be corrected.
    - Oak Park Place will be in compliance by July 31, 2016.

Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #3 no longer resides at Oak Park Place.

2. What measures will be taken to ensure the problem does not recur.
    - The RN and staff responsible for setting up medications for administrations will be re-educated.

- Staff responsible for medication administration will be retrained on comparing the medication to be administered to the MAR to ensure medications are administered as ordered.

3. How the Program plans to monitor performance to ensure compliance.
   - The RN Director or designee will review medication administration at least every 90 days when completing a 90-day nurse review. This process will include a review of physician orders to ensure orders are current and being administered as ordered by the physician.

4. The date by which the regulatory insufficiency will be corrected.
   - Oak Park Place will be in compliance by July 31, 2016.

Tenant Documents – Completion of an Incident Report for a Medication Error

1. Elements detailing how the Program will correct each regulatory insufficiency.
   - Tenant #4 will have medications administered as ordered by the physician.
   - Incident report forms will be completed when there is a medication error.

2. What measures will be taken to ensure the problem does not recur.
   - Staff responsible for medication administration will be re-delegated on medication administration.
   - The RN and staff responsible for completion of incident report forms will be retrained on Oak Park Place's Incident Reporting Policy and Procedures.

3. How the Program plans to monitor performance to ensure compliance.
   - The RN Director or designee will review medication administration and Incident Reporting at least every 90 days when completing a 90-day nurse review.

4. The date by which the regulatory insufficiency will be corrected.
   - Oak Park will be in compliance by July 31, 2016.

Please contact me at 563-585-4900 with any questions you have. Thank you.

Sincerely,

Dara Fishnick
Director of Housing