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
	S0143	A. BUILDING: _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK ASSISTED LIVING	1121 FREMONT STREET IOWA FALLS, IA 50126

(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 Number of tenants without cognitive disorder: 39 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 43 TOTAL census of Assisted Living Program: 43 During the recertification visit to determine compliance with certification rules for an Assisted Living Program the following regulatory insufficiency was cited.	A 000		
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 interview and review of program documentation the Program failed to follow its medication policy to administer medications as ordered by a physician for 9 out of 34 tenants (Tenants #5 #6, #7, #8, #9, #10, #11, #12, and	A 147		

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A 147	Continued From page 1 #13). Findings follow: 1. Record review for Tenant #5 on 11/1/16 revealed the following: a. A Medication Error Report dated 9/5/16 revealed the EMAR (Electronic Medication Administration Record) indicated the noon doses of amiodarone 200 mg. and losartan 100 mg. were administered when in fact they had not been. b. A Medication Error Report dated 7/4/16 indicated losartan 100 mg and potassium 100 mg from the a.m. shift were still in bubble packs but had been documented as being administered on the EMAR. c. Tenant #5's service plan dated 10/27/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders. 2. Record review for Tenant #6 on 11/1/16 revealed the following: a. A Medication Error Report dated 9/20/16 indicated "EMAR charted as medications administered; however, medications not administered" for the bedtime dose of lovastatin 20 mg. b. Tenant #6's service plan dated 10/27/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders. 3. Record review for Tenant #7 on 11/1/16 revealed the following: a. A Medication Error Report dated 9/9/16 indicated "EMAR charted as medications administered; however, medication not administered" for the evening dose of potassium (KCl) 20 milliequivalents per liter (MEq). b. Tenant #7's service plan dated 9/2/16	A 147		

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A 147	Continued From page 2 indicated Program staff were responsible to provide reminders to take medications according to physician orders. 4. Record review for Tenant #8 on 11/1/16 revealed the following: a. A Medication Error Report dated 9/20/16 indicated "EMAR charted as medication administered; however, medication not administered" for the evening dose of spirinolactone 25 mg. b. Tenant #8's service plan dated 9/12/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders. 5. Record review for Tenant #9 on 11/1/16 revealed the following: a. A Medication Error Report dated 9/9/16 indicated "EMAR charted as medication administered; however, medication not administered" for the morning doses of hydrochlorothiazide (HCTZ) 12.5 mg, vitamin D 1000 units, losartan 50 mg, citalopram 20 mg, furosemide 20 mg, KCl 10 meq. b. Tenant #9's service plan dated 7/22/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders. 6. Record review for Tenant #10 on 11/1/16 revealed the following: a. A Medication Error Report dated 9/13/16 indicated "EMAR charted as medication administered; however, medication not administered" for the noon dose of pentaxifylline extended release (ER) 400 mg. b. Medication Error Report dated 9/22/16 indicated "EMAR charted as medication administered; however, medication not	A 147		

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A 147	Continued From page 3	A 147		

administered" for the morning doses of Eliquis 25 mg, furosemide 40 mg, levothyroxine 50 mg, KCl ER 20 mg.

c. A Medication Error Report dated 7/24/16 indicated the noon dosage of pentoxieylline ER 400 mg was still in bubble pack and not given.

d. Tenant #10's service plan dated 10/27/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders.

7. Record review for Tenant #11 on 11/1/16 revealed the following:

a. A Medication Error Report dated 7/24/16 indicated noon medications B12 and gabapentin 300 mg were still in bubble pack and marked on EMAR that it was given.

b. A Medication Error Report dated 7/24/16 indicated supper medication dipentum 250 mg was still in bubble pack but marked on EMAR that it was given.

c. Tenant #11's service plan dated 8/29/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders.

8. Record review for Tenant #12 on 11/1/16 revealed the following:

a. A Medication Error Report indicated a.m. medication potassium chloride 20 mcq was still in bubble pack and marked on EMAR that it was given for the following dates: July 4, 23, and 28, 2016.

b. A Medication Error Report dated 7/21/16 indicated 7:00 a.m. vitamin tablet was still in bubble pack but marked on EMAR as given.

c. Tenant #12's service plan dated 8/8/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders.

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A 147	Continued From page 4 9. Record review for Tenant #13 on 11/1/16 revealed the following: a. A Medication Error Report dated 7/15/16 indicated a.m. amlodipine 2.5 mg was still in bubble pack but marked on EMAR that it was given. b. A Medication Error Report dated 7/15/16 indicated a.m. aspirin (ASA) 81mg was still in bubble pack. c. Tenant #13's service plan dated 9/12/16 indicated Program staff were responsible to provide reminders to take medications according to physician orders. 10. Interview with the Registered Nurse on 11/1/16 at 2:30 pm revealed staff were not watching tenants take the medications as required at times. Staff were leaving the medication in the tenant's apartment then leave. They would then sign off on the EMAR that the medication was given. Later, if the med was found still sitting in the tenant's apartment, staff put them back into the bubble pack. 11. Review of the Assistance with Taking Medications policy revealed the staff person administering medications should observe the medication being taken.	A 147		

VRK 12/14/16

Ashbrook Assisted Living

1121 N. Fremont St., Iowa Falls, Iowa 50126 ■ 641-648-8080

December 7, 2016
RE: Plan of Correction

Facility: Ashbrook Assisted Living
Date of Monitoring: November 1-3, 2016
Monitor: Mary Hildreth and Jana Smith

Dear Ms. Kellen,

Regulatory Insufficiency: 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 as per 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.

1. Elements detailing how the Program will correct each regulatory insufficiency.
    a. Prior to recertification it was recognized through chart audits (October 25, 2016) that delegated staff were not observing tenants taking medications. On October 26, 2016 education was provided to delegated staff that they must visualize tenants taking all medications as indicated per the service plan and appropriately document the outcome.

2. Measures taken to ensure the problem does not recur.
    a. Re-education to all delegated staff by RN to include
        i. Update orientation/training process for delegation of medications to ensure compliance of policy
        ii. Delegated staff will observe tenants taking medications
        iii. Delegated staff will accurately document the outcome
        iv. RN will be notified of any refusals
    b. Education to current/future tenants on options for Medication Assistance

3. How the Program plans to monitor performance to ensure compliance.
    a. Random audits of med pass
    b. RN will compare current medications to Medication Administration Record to ensure accuracy

4. The date by which the regulatory insufficiency will be corrected.
    a. This regulatory insufficiency will be completed by December 16, 2016.

Sincerely,

Julie Feeney RN ALD

Julie Feeney, RN ALMC
1121 N. Fremont St.
Iowa Falls, IA 50126
(p) 641-648-8080