DEPARTMENT OF INSPECTIONS AND APPEALS

OK 10/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0299	A. BUILDING: _____ B. WING _____	C 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT DES MOINES	5815 SE 27TH STREET DES MOINES, IA 50320

(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: 44 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 44 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 22 Total Population of Program at time of on-site: 22 TOTAL census of Assisted Living Program: 66 The following regulatory insufficiencies were cited during the investigation of Complaint #69718-C.	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:	A 147		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DD 10/12/17

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A 147	Continued From page 1 Based on interview and record review the Program failed to ensure medications were administered as prescribed for 9 out of 44 tenants reviewed. Findings include: On 8/31/17 at 12:14 p.m incident report review revealed several medication errors for the months of May 2017, June 2017 and July 2017. According to the incident reports: - On 5/6/17 at 8:15 a.m. staff administered Tenant #3's a.m. medications twice. Medications included one 500mg. tablet (tab) APAP, one 81mg. tab of aspirin, one tab B-Complex, one 20mg. tab Furosimide, one 600mg. tab Gabapentin, 1/2 of a .5mg. tab of Lorazepam, one 10mg. tab Memantine, 1/2 of a 25mg. tab of Metoprol, one 20mg. capsule of Omeprazole, one potassium chloride micro tab 20Meq ER and one Vitamin D3 5000 unit capsule. - On 6/19/17 at 8:00 a.m. staff administered discontinued medications to Tenant #4. The medications were one 10mg. tablet of Amlodipine and 1/2 of a 10mg. tablet of Baclofen. These meds had been discontinued on 6/15/17. - On 7/3/17 Tenant #5's 7mg. of Warfarin was not given at bedtime. - On 7/3/17 Tenant #6's 10mg. tab of Aricept and 20mg. tablet of Pepcid were not given at bedtime but were documented on the Medication Administration Record (MAR) as administered. - On 7/3/17 Tenant #7's 1 mg. tab of Sucralfate was not given at bedtime but was documented on the MAR as administered. - On 7/3/17 Tenant #8's bedtime meds were not given but were documented on the MAR as administered. The meds were two 325mg. tabs APAP, one 1200mg. cap Fish Oil, one 25mg. tab Metoprol TAR and two 8.6mg. tabs of Senna. The tenant's Trazadone was also not given but the	A 147	A 147 481-67.5(6)d Medications 481-67.5(231B, 231C, 231D When any medication or treatment is not administered/completed for any reason (refusal, non-availability, etc.), staff will be re-educated that it is to be circled on the MARS, the reason/explanation written on the back of the MARS, the Nurse to be notified in writing; the Nurse will notify the physician if resident refuses medication more than two days. Nurse will notify pharmacy if the medication is not available after one day. Medication administration records issues will be discussed in Nurse Review each Friday. Attendance in Nurse review will include the Executive Director, AED, RN, LPN and Memory Care Coordinator. Medication errors disciplinary action will in implemented as follows: First medication administration error: employee will be retrained; Verbal Counseling will occur. Second medication administration error: employee will be pulled from med administration until re-delegation is completed; written counseling will occur. Third medication error or severe med error: employee will be pulled indefinitely from medication administration: disciplinary action up to and including termination. This policy to be implemented 10/06/17	

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A 147	Continued From page 2 MAR had been left blank for that med. - On 7/3/17 Tenant #9's 500mg. tab APAP was not given at bedtime. The MAR had been left blank without explanation as to why the med was not given. - On 7/3/17 Tenant #10's 500mg. tab Metformin was not given in the evening. The MAR had been left blank without explanation as to why the med was not given. On 8/31/17 at 3:14 p.m the Administrator confirmed these findings and reported the two staff that were responsible for the aforementioned errors had been terminated. On 9/05/17 at 12:46 p.m. review of Tenant #2's MAR for the month of June 2017 revealed his/her Breo Ellipta Inhaler 100-25 (inhale one puff by mouth every evening) had not been administered for the entire month. Staff had initialed Tenant #2's MAR and circled their initials. In addition the tenant's 150mg. cap Venlafazine Cap ER had been initialed and circled by staff from 6/16/17 through 6/26/17. No explanations were documented as to why these meds/treatments had not been given. Review of Tenant #2's file revealed renewal orders dated 6/15/17 for both the Venlafazine and Breo Ellipta Inhaler. On 8/30/17 at 2:42 p.m. review of the Program's medication policy revealed if medications were not administered, the reason for the omission was to be recorded on the MAR. On 9/05/17 at 4:10 p.m. Staff B confirmed there were no explanations on Tenant #2's June MAR regarding why the medications/treatments had not been administered. Further investigation by Staff B revealed the medications had not been filled by the pharmacy due to a delay in insurance.	A 147		

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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 staff interview and record review the Program failed to update service plans at least annually for 1 of 4 tenants reviewed (Tenant #1). Findings include: On 9/05/17 at 12:00 p.m. review of Tenant #1's service plan revealed it was last dated 7/29/16. On 9/05/17 at 1:26 p.m. Staff B confirmed the Program had not updated Tenant #1's service plan since 7/29/16.	A 083	A083 481-69.26(1} Service Plans Service plans will be included in the daily Nurse Review. Records be reviewed for 30, 90 days, Change of Condition and Annual services plans will be reviewed and scheduled for completion. This schedule will be documented in the daily (Monday- Friday) Nurse Review notes. Attendance in Nurse review will include the Executive Director, AED, RN, LPN and Memory Care Coordinator. All Service plans will be completed within the time period set by the Iowa Code. Implementation Date 10/06/17	