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 |
|---|---|---|---|
| | S0082 | A. BUILDING: _____ B. WING _____ | 09/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNWOOD ASSISTED LIVING | 302 W LINCOLN EDGEWOOD, IA 52042 |

| (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 | Initial Comments<br><br>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.<br><br>Number of tenants without cognitive disorder: 29<br>Number of tenants with cognitive disorder: 1<br><br>TOTAL census of Assisted Living Program: 30<br><br>The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program: | A 000 | See attached POC 11/15/18 | |
| A 013 | 481-67.3(2) Tenant Rights<br><br>481-67.3 Tenant rights. All tenants have the following rights:<br>67.3(2) To receive care, treatment and services which are adequate and appropriate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the Program failed to ensure tenants consistently received adequate and appropriate services. This pertained to 1 of 5 tenants reviewed (Tenant #5). Finding follows:<br><br>When interviewed on 9-12-18 a tenant reported a concern with not receiving bedtime medications in a timely manner. She said it had occurred twice since she was admitted; including a time recently. The tenant normally received bedtime | A 013 | | |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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| A 013 | Continued From page 1 | A 013 | | |

medications at 7:00 p.m. At 9:00 p.m. the tenant used the pendant to call for staff. Two staff arrived (from the attached nursing facility) within 5 to 10 minutes; however, the two staff that responded could not administer medications. Staff told the tenant they would get someone to assist. At 11:00 p.m. the tenant used the pendant to call for assistance as medications had not been administered. A nurse responded within 5 to 10 minutes and said she had not received a message to administer the medications. The nurse administered the medications at 11:00 p.m.

Record review on 9-12-18 of the September 2018 medication administration records (MARs) reflected 14 tenants received assistance with medications and/or treatments at bedtime on 9-7-18. Staff A initialed the completion of bedtime medications and treatments for 13 of 14 tenants on 9-7-18. Staff B initialed the administration of bedtime medications for 1 of 14 tenants (Tenant #5) on 9-7-18.

Continued record review on 9-12-18 of the schedule indicated Staff A was listed the staff for 4:30 p.m. to 7:30 p.m. on 9-7-18. The staff listed to administer p.m. medications was crossed out on the schedule for 9-7-18.

When interviewed on 9-13-18 at 10:15 a.m. Staff A said she worked on Friday (9-7-18) from 4:30 to 8:30 p.m. She provided assistance including bedtime cares and medications. Staff A said she must have missed Tenant #5, regarding the administration of medications on 9-7-18. Tenant #5 did not use her pendant to call for assistance that evening.

When interviewed on 9-12-18 at 3:11 p.m. Staff B said she worked third shift at nursing facility and

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| A 013 | Continued From page 2 | A 013 | | |

assisted at the Program when pendant calls were received and she completed nightly checks. On Friday (9-7-18) she worked from 10:00 p.m. to 6:00 a.m. at the nursing facility. At approximately 10:20 p.m. to 10:25 p.m. Tenant #5 activated her pendant and Staff B responded. Tenant #5 reported she had previously told someone she not received her medications; however, it was not clear if the staff Tenant #5 had told about the medications were from the nursing facility or Program. Tenant #5 was upset about not getting her medications and was anxious. Staff B looked at the MARs and cassettes and the bedtime medications were in the cassette for Friday and the MARs had not been signed off. Staff B administered the medications to Tenant #5 before 10:30 p.m. on 9-7-18. She left a note for the Assisted Living Director; however, a medication error report was not completed. She was not aware of any other tenants that did not receive bedtime medications on 9-7-18.

When interviewed on 9-12-18 at 12:42 p.m. and on 9-13-18 at approximately 1:45 p.m. the Assisted Living Director said during the morning medication pass on either Monday or Tuesday (of this week), Tenant #5 made her aware she had an issue with medications on Friday. Tenant #5 reported she had not received her bedtime medications by the normal time. At about 8:00 p.m. two staff from the nursing facility came over and then a nurse came back over. Tenant #5 received her medications at approximately 10:00 p.m. There was no adverse outcome noted and a medication error report was not completed.

When interviewed on 9-18-18 at 9:15 a.m. the Pharmacist revealed the therapeutic range for Alprazolam was four to six hours. Tenant #5's physician ordered the medication twice daily. The

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| A 013 | Continued From page 3 | A 013 | | |

policy for twice daily dosing would be at 7:00 a.m. and 7:00 p.m. unless they were notified differently.

Continued record review on 9-13-18 of a statement from the Assisted Living Director reflected Tenant #5 used her pendant at 8:14 p.m. and 10:14 p.m. on 9-7-18. The time it took to reset the pendant from the 8:14 p.m. pendant activation could not be retrieved. The pendant was reset at 10:16 p.m. from the 10:14 p.m. pendant activation.

Further record review revealed a statement signed by the physician on 9-14-18 revealed the physician was aware Tenant #5's bedtime medications were administered at 10:00 p.m. on 9-7-18. Tenant #5 had no adverse effects from the administration time. The physician indicated the occurrence would not constitute a medication error.

Continued record review on 9-12-18 of Tenant #5's file revealed diagnoses included: major depressive disorder and anxiety disorder. The service plan dated 8-1-18 reflected staff administered medications, including Alprazolam twice a day.

✓ 11/9/18 DC 11/8/18

# Lincolnwood Assisted Living

302 West Lincoln ❖ Edgewood, Iowa 52042 ❖ 563/928-6461
Fax: 563/928-6462

October 15, 2018

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

Dear Ms. Campbell:

On behalf of Lincolnwood Assisted Living in Edgewood, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dated September 18, 2018. 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 provision of state law.

**Tenant Rights**

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #5 will have medications administered as ordered by the physician and in accordance with the tenant's service plan.

2. What measures will be taken to ensure the problem does not recur.
    - Staff will be re-educated on medication administration protocol.
    - The RN will review medication administration time frames and ensure staff responsible for medication administration is appropriately delegated to perform task.

3. How the Program plans to monitor performance to ensure compliance.
    - The RN and/or Designee will audit the MARs at least every 90 days for compliance.
    - The RN will review medication administration when completing the 90 day nurse review with tenants who receive program assistance with medication administration to determine if there are any concerns.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by November 15, 2018.

If you have any questions regarding this plan of correction, please feel free to contact me at 563-928-7173. Thank you.

Sincerely,

Sara McCool
Administrator