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
	S0111	A. BUILDING: _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWN DEER PLACE	1500 1ST AVE N CORALVILLE, IA 52241

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 3 Number of tenants with cognitive impairment: 13 Total census: 16 The following regulatory insufficiencies were cited during the investigation into Complaint #122166-M and Incident #121938-A.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, program staff failed to follow the program's policy on Medication and Medication Administration and the policy on Adult Abuse Reporting for 1 of 4 tenants reviewed (Tenant 1). Findings include: Review on 10/7/24 of an internal investigation completed by the program identified an incident on 7/6/24 in which Staff A admitted to giving Tenant #1 more of the medication, Risperidone, than prescribed, but stated she stopped doing this as of 7/6/24. Interviews with other staff revealed they reportedly did not have any knowledge of this occurring until Staff B had	A 150	Staff A was terminated from the program on 07/17/2024. All staff received re-education on 10/10/2024 related to Adult Abuse Reporting, Medication storage & administration, Tenant Rights, Incident reporting, and documentation. Staff education/re-education will be provided on hire, annually and as needed	

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

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suspicions of such practices on 7/6/24.

A review of physician's orders for Tenant #1 dated 7/15/24 revealed she was to receive 0.5 ML of Risperidone Solution 1 mg/ML three times daily, beginning on 5/3/24. Tenant #1 was to get the medication at 8:00 AM, noon and 8:00 PM.

On 10/8/24 at 10:45 AM Staff B stated she witnessed Staff A drawing a syringe of Risperidone on 7/6/24 with too much medication in it. She then observed Staff A with a medication bottle in her hand which she appeared to try and hide by keeping her arms folded. Staff B said she asked Staff A if she had given Tenant #1 the medication as Staff B was aware the medication should not be administered until 8:00 PM. Staff A stated she was getting it ready for later. Staff B then witnessed Staff A discard the medication bottle in the trash. Staff A dug out the discarded bottle from the trash and confirmed the medication bottle was for Tenant #1. Staff B then asked another staff (Staff C) if Staff A usually drew up the medication early and Staff C confirmed it was common for Staff A to prepare medication early and administer the medication at dinner time instead of the prescribed time of 8 PM. Staff B then went into the kitchen and discovered Staff A had left the pre-filled full syringe in the unlocked kitchen cabinet. Staff B stated she confronted Staff A about the incorrect dosage and stated she instructed Staff A to call the nurse and inform the nurse of the error. Staff B stated she did not notify the nurse of the error until Monday, 7/8/24.

When interviewed on 10/8/24 at 1:30 PM Staff C stated she observed the pre-filled syringe for Tenant #1 and knew it contained more than the prescribed amount of Risperidone. Staff C was

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aware Staff A generally pre-filled the syringes and would keep them in the community kitchen cabinet until dinner but was unsure whether Tenant #1 received more than the prescribed amount on other dates. Staff C recalled Staff A said things such as she should give Tenant #1 more medicine to put her to sleep. Tenant #1 was sleeping more during this time. Her co-workers questioned if this was because Staff A was giving Tenant #1 more medicine. Staff C did not provide any names of the co-workers. Staff C did not report any of these concerns to the Health Care Coordinator (HCC) or the Executive Director.

On 10/8/24 at 2:05 PM Staff D stated she was aware Tenant #1 was ordered to receive Risperidone at 8 AM, noon, and 8 PM but a lot of staff, including Staff A, were giving it to Tenant #1 at suppertime because the tenant didn't like to take it at bedtime. Staff put it in her coffee at supper. Staff D further stated she occasionally observed different dosages in the syringe; sometimes observing it at .5 ml and other times observing it at 1 ml which she believed was the maximum amount the syringe could hold. Staff D stated she was unaware of the amount of Risperidone Tenant 1 was supposed to receive so never reported it to anyone. There were times Staff D witnessed Staff A get aggravated with the tenant. In her opinion, Staff A got out of hand. She was unable to provide specific examples, but believed Staff A should have walked away from the tenants sooner than she did. Staff D did not report her concerns regarding Staff A to anyone.

On 10/16/24 at 2:03 PM, Staff E reported Staff A got easily annoyed with Tenant #1. Staff A got in Tenant #1's face, tried to demean her and tried to instill fear in her. She confirmed Tenant #1 was hard of hearing, but denied Staff A was only trying

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to make herself heard. Staff E did not put her concerns in writing, but believed she spoke with the former Health Care Coordinator about her concerns.

A review of the program's policy entitled Medication and Medication Administration instructed staff to consistently follow the six "Rights" for proper and accurate administration of medicines and included (but not limited to) the following steps: #2. Right dose - Always be sure that you are giving the prescribed amount of medication. Too much may be dangerous, too little maybe ineffective. #3. Right time - Specific timing may be important for certain drugs to be most effective. If a certain time is specified for the medication, it needs to be given only at that time. The policy further educated staff: Perhaps the most important concept about the "Six Rights" is that a violation of any right constitutes a medication administration error. Thus, if any mistake is made, it should be reported immediately to the on-call nurse so counter measures to solve any resulting problems can be taken. A medication error report form must also be completed and submitted to the RN on-call.

On 10/8/24 review of the program's policy entitled Adult Abuse Reporting included the following staff instructions: "If you suspect a dependent adult has been abused, you must report it to the Director or Nurse immediately," and "The employee who witnesses or becomes aware of abuse or suspects abuse should immediately notify the person in charge."

On 10/8/24 at 3:26 PM the Regional Nurse Specialist stated staff should have called the nurse on-call on 7/6/24 per policy instead of completing a nurse communication sheet or

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A 150	Continued From page 4 waiting until the following Monday to verbally report the misuse of the medication and suspicion of abuse. On 10/9/24 at 10:45 AM the Executive Director confirmed the above findings.	A 150		
A 191	481-67.3(9) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(9) To be free from restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure appropriate services were provided to protect 1 of 4 tenants reviewed from being subjected to chemical restraints (Tenant #1). Findings include: 1. Review of Tenant #1's record on 10/7/24 revealed she moved into the program on 3/12/24 with diagnoses including Alzheimer's disease and severe dementia with behavioral disturbance. Her service plan, dated 4/12/24, indicated she had a severe memory impairment and was frequently disoriented. Tenant #1 had occasional behavioral issues and was known to be disruptive, aggressive or have socially inappropriate behavior. She could get very loud with staff or others when things did not go as she wanted them to. She had a history of wandering. Tenant #1's progress notes revealed the following:	A 191	**Staff A was terminated from the program on 07/17/2024. All staff received re-education on 10/10/2024 related to Adult Abuse Reporting, Medication storage & administration, Tenant Rights, Incident reporting, and documentation. Staff education/re-education will be provided on hire, annually and as needed**	

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- on 3/13/24 the tenant yelled 911 repeatedly while being agitated and exit-seeking.
- on 3/22/24 the tenant refused to shower, change clothes or sleep in her own room
- on 3/25/24 it was noted the tenant refused medications over the weekend
- on 4/5/24 the tenant kept asking to get in her car and leave every few minutes
- on 4/12/24 she breeched the doors of the memory care unit setting off the alarms
- on 4/18/24 she scratched her legs until they bled, put her bloody legs on the furniture and cussed at staff.
- on 4/29/24 the tenant was yelling at staff and going into others' apartments near midnight.

2. A review of an internal investigation dated 7/12/24 revealed on 7/8/24 at 11:30 AM, Staff B informed the former Health Care Coordinator (HCC) Staff A potentially gave Tenant #1 a higher dose of her scheduled liquid Risperidone than was ordered. Staff B saw Staff A come out of the medication room with something in her hand, which she threw in the trash. Staff B walked to the trash and looked for the item and saw Tenant #1's empty bottle of Risperidone. On 7/9/24 at 11:30 AM, the Executive Director and HCC interviewed Staff A who said she did not want to deal with Tenant #1's behaviors, but had since stopped giving the tenant extra medication. Staff A was suspended on 7/9/24 pending the conclusion of the investigation. The HCC completed a physical assessment and Tenant #1's vital signs were stable. She was more sleepy than normal over the weekend but back to normal on 7/10/24.

The Regional Nurse Specialist wrote in the internal investigation she spoke with a representative of the pharmacy and learned the

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pharmacy dispensed 30 ml bottles of Risperidone on 4/19/24, 5/3/24, 5/17/24, 5/29/24, 6/11/24, 6/24/24, 7/1/24 and 7/5/24 (240 ml total). A review of Tenant #1's Medication Administration Record (MAR) from 4/19/24 - 7/9/24 revealed a total of 105 ml's should have been administered to Tenant #1. The Risperidone bottle dispensed on 7/5/24 could not be located. The bottle filled on 7/1/24 had approximately 25 ml's left. There were approximately 90 ml's of Risperidone which were unaccounted for.

Staff A admitted to giving Tenant #1 more Risperidone than prescribed by her Primary Care Provider (PCP) when interviewed, according to the internal investigation, but said she stopped doing this as of 7/6/24. Staff interviewed revealed staff had no suspicions this was occurring until 7/6/24.

3. A review of Tenant #1's MAR for May, 2024 revealed she received 0.5 ml of Risperidone twice daily (at noon and 8:00 PM) from 5/1/24 to 5/3/24. Beginning on 5/4/24, Tenant #1 received 0.5 ML of Risperidone three times daily (noon, 2:00 PM and 8:00 PM). One bottle of medication should have lasted approximately 20 days. The Risperidone was filled more frequently than every 20 days.

A visit note from Tenant #1's Primary Care Provider (PCP) on 6/14/24 noted at that time she was becoming quite drowsy during the day. The program nurse was not sure the PCP should change the Risperidone to a pill form to be certain Tenant #1 was getting the correct amount of medication.

Review of a police report narrative dated 9/27/24 revealed on 9/13/24 at 1:00 PM, Staff A stated

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she was dealing with an extra physical and mental load at work. She slowly gave Tenant #1 an increasing dose of Risperidone to manage her behaviors. She administered higher doses when Tenant #1 did not appear to be harmed.

4. On 10/16/24 at 9:45 AM, the former HCC reported she only worked for the program for about 1.5 months. During her time working there, she heard from the staff Tenant #1 was lethargic and not herself. She working with Tenant #1's PCP to get lab work to try and determine the cause of the lethargy. Tenant #1 would be more lively in the morning but sedated in the afternoon. Staff A often worked in the afternoon. Tenant #1 was able to be roused and her vitals were fine but they could not determine what was wrong with her. She stated she kept getting notifications from the pharmacy they were getting requests to refill the Risperidone too early but she did not inquire more deeply into this because she was often being sent off to other buildings and could not focus on tenant care.

When interviewed on 10/8/24 at 10:45 AM, Staff B reported she walked into the medication room on 7/6/24 in the afternoon and saw Staff A drawing up a syringe of Risperidone for Tenant #1 all the way full (3 MLs - six times the prescribed dose). It would not have been appropriate to prepare medication in the afternoon for the 8:00 PM dose of medication. Staff B confronted Staff A about the amount of medication in the syringe and she believed Staff A emptied the excess medication into the bottle. Staff B asked Staff A to report this to the nurse but this did not happen. Staff B did not immediately notify the HCC or Executive Director. She recalled the night before (7/5/24), she overheard Tenant #1 tell Staff A she did not like her medication because it made her

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A 191	Continued From page 8 feel very wobbly and like she could barely walk. Staff B did not notice the Risperidone causing this side effect to Tenant #1 when she administered the medication. On 10/8/24 at 1:33 PM, Staff C reported seeing a syringe of Risperidone on 7/6/24 for Tenant #1 with too much medication in it. She was also aware each time she worked with Staff A, the employee administered the tenant's 8:00 PM medication at dinnertime (4:30 PM - 5:00 PM). More than once, Staff C heard Staff A say something about giving Tenant #1 medicine to put her to sleep. Staff C recalled during this period Tenant #1 was sleeping more. People wondered what was wrong as the tenant was not asking questions like she normally did. Some of the co-worker's thought it was because Staff A was giving her more medication. Staff C declined to name the co-workers, saying she could not remember their names. During an interview on 10/8/24 at 2:05 PM, Staff D reported she saw Staff A give Tenant #1 syringes with 0.5 ML, 1.0 ML or more Risperidone at dinnertime. Other employees also gave Tenant #1 Risperidone at dinnertime rather than at 8:00 PM. On 10/9/24 at 10:45 AM, the Executive Director and Regional Nurse Specialist confirmed these findings.	A 191		
A 275	481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following:	A 275		

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A 275	Continued From page 9 f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, staff failed to ensure medications were stored in a locked area for 1 of 4 tenants reviewed (Tenant 1). Findings include: On 10/7/24 review of Tenant 1's service plan revealed the program was responsible for ordering, handling, storage and administration of her medications. It indicated Tenant 1's medications may be stored in a centrally locked medication room, nurses's office or refrigerator according to manufacturer's directions; or medications may be stored in Tenant 1's apartment in a locked cupboard/drawer. On 10/8/24 at 10:45 AM, Staff B stated she witnessed Staff A drawing a syringe of liquid Risperidone for Tenant #1 in the storage room on 7/6/24. Staff B later went into the community kitchen and discovered Staff A had left the pre-filled syringe in the unlocked kitchen cabinet. All tenants who lived in the program had access to the community kitchen. On 10/15/24 at 2:00 PM, Staff A reported she usually took all tenants' evening medications to the kitchen area in the afternoon. Generally she put two medication cups with tenant medications and the syringe with Risperidone in the unlocked kitchen cupboard. Staff A reported she and other	A 275	**Staff A was terminated from the program on 07/17/2024.** **All staff received re-education on 10/10/2024 related to Adult Abuse Reporting, Medication storage & administration, Tenant Rights, Incident reporting, and documentation. Staff education/ re-education will be provided on hire, annually and as needed.** **New hire RN will be/has been educated on policies and procedures including medication. New hire RN will/has completed staff delegation verification of medication passers.**	

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A 275	Continued From page 10 staff also put medication in the white cabinets in the nurse's station prior to the medication pass such as eye drops and pills in medication cups. They did this to prepare for the next medication pass. On 10/16/24 at 9:45 AM, the former Health Care Coordinator (HCC) stated during her brief employment at the program some of the medication managers did put medication in unlocked cupboards in the nurse's station as shortcuts to try and save time during the medication administration process. The program's Medication and Medication Administration Policy revealed when the assisted living program stored a tenant's medications, the medications would be kept in a locked location which was not accessible to people other than employees responsible for the supervision of such medications. On 10/9/24 at 10:45 AM the Executive Director confirmed the above findings with the potential to affect all other tenants who resided in the memory care area of the program.	A 275		