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
	S0168	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS ASSISTED LIVING	**512 13TH STREET WELLMAN, IA 52356**

(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 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: Number of tenants with cognitive impairment: 1 Total census: 1 The following regulatory insufficiencies were cited during the investigation of Complaint #118726-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments 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 record review, the program failed to administer medication in accordance with physician's orders for 1 of 2 discharged tenants reviewed (C1). Finding follows: On 6/20/24 a complainant indicated program staff	A 285		

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discovered two Fentanyl patches on Tenant C1 on or around 1/26/23. Tenant C1 had an order for one Fentanyl patch at a time to be applied. According to the complainant, Tenant C1's health status deteriorated with both patches applied and she was never the same afterwards. The complainant said a similar incident happened within a couple week of the first incident, when staff again noted two Fentanyl patches applied to Tenant C1. The tenant transferred to the long term care facility in June 2023, where she passed away a few weeks later.

On 6/24/24 record review revealed Tenant C1 was 76 years old at the time of the reported incident, with a diagnosis including Alzheimer's Disease; anxiety disorder; major depressive disorder; essential hypertension; dysphagia, hypothyroidism and hyperlipidemia. Progress notes for Tenant C1 indicated a referral was made to hospice on or around 1/05/23. The Advance Registered Nurse Practitioner (ARNP) documented a new order on 1/11/23 for Fentanyl 12 mcg transdermal patch every 72 hours. A progress noted dated 2/08/23 indicated Tenant C1's Fentanyl patch should have been changed on 2/07/23, per the order to change it every 72 hours, but the new patch was applied on 2/08/23. No additional progress notes regarding a medication error related to the Fentanyl patch could be located.

The ARNP wrote an order dated 1/11/23 for Fentanyl 12 mcg transdermal patch one time every three days for pain.

The ARNP wrote an order dated 1/29/23 for staff to initial and date the Fentanyl patches, remove the previous patch and write placement of patch on MAR.

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Tenant C1's January 2023 medication administration record (MAR) revealed she began receiving Fentanyl patch 12 mcg transdermally every 72 hours on 1/14/23. One staff person initialed the removal of the old patch and another staff initialed the application of the new patch. According to the January MAR, staff should have removed the old Fentanyl patch on 1/29/23 and applied a new patch. Staff documented "NA" for the removal of the patch on 1/29/23 and left blank the entry for the application of the new patch. Staff documented "NA" for the removal of the old Fentanyl patch on 1/30/23, but initialed they applied a new patch (four days after application of previous patch on 1/26/23). Staff documented they removed the old patch on 1/31/23 and applied a new Fentanyl patch. (On 6/27/24 at 3:40 p.m. the former Assisted Living Director stated "NA" indicated "not available".)

According to Tenant C1's February MAR, staff documented they removed the old Fentanyl patch on 2/01/23 and applied a new patch. Staff documented they applied a new Fentanyl patch three days in row: 1/30/23, 1/31/23 and 2/01/23. The February MAR revealed Tenant C then received the Fentanyl patch every three days as ordered, with the exception of a missed dose on 2/07/23, which she received on 2/08/23.

On 6/25/24 at 10:40 a.m. the Administrator and former Assisted Living Director (ALD, current Business Development Liaison) both recalled at least one incident, and possibly two incidents, when staff discovered two Fentanyl patches on Tenant C1. The former ALD said the program addressed the problem by having two staff present when the Fentanyl patch was changed, to ensure the old patch was removed prior to the

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A 285	Continued From page 3 new patch being applied. On 6/26/24 the Administrator verified the medication error regarding when two Fentanyl patches were discovered on Tenant C1 and indicated the program should have completed documentation regarding the medication error(s). On 7/01/24 at 2:00 p.m., the Administrator and former ALD confirmed the staff documented they applied Tenant C1's Fentanyl patch on three consecutive days: 1/30/23, 1/31/23 and 2/01/23, which did not follow the orders of the prescribing ARNP for one patch to be applied every 72 hours. Review of the program's medication administration policy revealed medication should be administered in accordance with the written orders of the prescriber.	A 285		