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
	S0285	A. BUILDING: _____ B. WING _____	C 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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. General Population Number of tenants without cognitive disorder: 28 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 6 Total Census of Program: 38 No regulatory insufficiencies were cited regarding the investigation of Incident 93963-I, the onsite infection control survey or the recertification visit conducted to determine compliance with certification rules for an ALP/D. The following regulatory insufficiency was cited during the investigation of Incident 95685-I.	A 000	5/19/21	
A 290	481-67.5(2)g Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 290	Plan of Correction is attached DD	

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

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A 290	Continued From page 1 Program failed to ensure the policy regarding narcotics was followed regarding 1 of 1 tenants identified in Incident #95685-I (Tenant C-1). Findings include: On 1/28/21 the Program filed a self-report concerning narcotics that were noted missing on 1/18/21 at approximately 10:00 a.m. on the memory care side of the Program. The missing narcotic belonged to a tenant since discharged (Tenant C-1). On 1/18/21 Staff B worked alone in the memory care unit. Staff B was a Resident Assistant (RA) who had been delegated on 11/13/20 to complete narcotic counts. Review of the instructions for the narcotics count task revealed narcotics were to be counted at every shift change. The oncoming and outgoing RAs went to each tenants' apartment who had narcotics and counted the number of controlled medications. The number was documented in the controlled medication binder and signed off by both staff. On 2/18/21 at 10:30 a.m. interview with the Clinical Care Specialist revealed narcotics were to be counted at every shift change at 6:00 a.m., 2:00 p.m. and 10:00 p.m. per policy. Review of the individual narcotic count sheet revealed on the morning of 1/18/21 Tenant C-1's morphine was noted as being counted by Staff B at 10:00 a.m. Staff B had started her shift at 6:00 a.m. Further review revealed the third shift staff who worked from 10:00 p.m. on 1/17/21 to 6:00 a.m. on 1/18/21 had not completed a count at the start of her shift when relieving Staff C who worked from 2:00 p.m. to 10:00 p.m. on 1/17/21. On 2/18/21 review of the Program's Medication Policy revealed medications stored by the	A 290		

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A 290	Continued From page 2 Program would be kept in a locked location. Staff who administered medications had a key to the locked location. Narcotics administered by the Program would be counted utilizing a narcotics count sheet at the RN's (Registered Nurse) discretion. Staff were to count and document the total number of narcotics at the beginning/end of each shift and after the administration of any narcotic. The Healthcare Coordinator was to do random counts on all narcotics administered by the Program. The RN and/or designee counted and recorded all narcotics delivered to the Program for medication managed residents. On 2/18/21 at 12:49 p.m. interview with Staff B revealed she had not counted Tenant C-1's morphine on 1/18/21 at 6:00 a.m. when she started her shift. She confirmed being aware of the Program policy concerning the counting of narcotics but stated she had been busy. Staff B said she counted the morphine at 9:00 a.m. on 1/18/21 without a witness and thought the count was correct but could not say she was 100% sure. Staff B had not documented this count. On 2/23/21 at 10:51 a.m. a follow-up interview with Staff B revealed on the morning of 1/18/21 she was informed by the hospice nurse that Tenant C-1 needed morphine. Staff B and the hospice nurse went to the secured room where the morphine was padlocked inside a red toolbox. Staff B unlocked the room and entered followed by the hospice nurse. Staff B unlocked the padlock on the toolbox and removed the syringes of morphine. The hospice nurse reached for one of the syringes of morphine and inadvertently knocked them out of Staff B's hands. All of the syringes fell to the floor. They did a count of the syringes as they picked them up and came up with 35. The narcotics count sheet indicated there should be a total of 37 syringes remaining,	A 290		

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A 290	Continued From page 3 leaving two syringes unaccounted for. Staff B reported the hospice nurse took one of the syringes and administered the morphine to Tenant C-1. Review of the tenant's MAR (Medication Administration Record) revealed Staff B signed off as giving the medication, when in reality it was the hospice nurse who did so. On 2/22/21 further review of Tenant C-1's narcotics inventory sheet revealed on 1/22/21 Staff C noted giving the tenant morphine at 3:00 p.m. and at 10:35 p.m. When these dates and times were compared to Tenant C-1's MAR only one administration of morphine was noted as being administered by Staff C. A follow-up interview with Staff C revealed she thought she had noted on the narcotic inventory sheet that one of the syringes she had documented as giving was an error. She stated the MAR was correct in showing only one syringe had been given. On 2/23/21 at 12:52 p.m. the Clinical Care Specialist confirmed entries on Tenant C-1's narcotics inventory sheet made by Staff C on 1/22/21 were not consistent with the MAR for that day. She also confirmed narcotic counts had not been completed each shift per Program policy. Finally, she confirmed Staff B had signed off on giving the tenant morphine on 1/18/21 when in reality, according to Staff B, the hospice nurse actually administered the medication.	A 290		

SunnyBrook
CARROLL
ASSISTED LIVING AND MEMORY CARE

5/19/21

Sunnybrook of Carroll

1214 East 18th Street Carroll, Iowa 51401

Date: 5/6/2021

Iowa Department of Inspection & Appeals
Deb Dixon
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

To Whom It May Concern,

Please consider this our plan of correction for the regulatory insufficiency cited during 2/18/2021 to 3/1/2021 Recertification Visit, Infection control Onsite Survey, and investigation of Incidents 93963-I and Incident 95685-I completed by the Department of Inspection and Appeals (DIA) in accordance with the Code of Iowa, section 231C and Iowa Administrative Code, chapter 481-69, pertaining to regulatory insufficiencies.

Plan of Correction (POC) Submitted For:

- Investigation Date: 2/18/2021 to 3/1/2021

481-67.5(2)g Medications

67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse.

The Program failed to ensure the policy regarding narcotics was followed regarding 1 of 1 tenants identified in Incident #95685-I (Tenant C-1)

A 290

1. **Elements detailing how the program will correct the regulatory insufficiency.**

5/12/21

Sunny Brook
CARROLL
ASSISTED LIVING AND MEMORY CARE

a. Cameras were installed where narcotics are centrally stored and counted by staff.
b. Staff members received counseling on Medication Policy and Narcotic Counting
c. Re-Delegation of Narcotic Counting was completed with staff.

2. **What measures will be taken to ensure the problem does not recur?**
   a. All staff was re-educated on Medication Policies by 2/4/21.

3. **How the program plans to monitor performance to ensure compliance.**
   a. Director or designee will provide daily, weekly, monthly, as needed, and as determined by the Director or designee to ensure continued compliance.

4. **Date by which the regulatory insufficiency will be corrected?**
   a. Regulatory Insufficiency will be corrected by 5/10/21.

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 regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Thank you for your time and consideration in correcting these important matters.

Sincerely,

Summer Martin, Community Director