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 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE 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 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: 31 Number of tenants with cognitive disorder: 5 Total Population of Program at time of on-site: 36 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 46 The following regulatory insufficiencies were cited during the investigation of Complaints #100219-C and 105235-C.	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:	A 285		

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

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A 285	Continued From page 1 Based on interviews and record review the Program failed to ensure medication administration as prescribed by the physician. This pertained to 1 of 5 tenants reviewed (Tenant #1). Findings include: Record review on 7/20/22 at 12:52p.m. revealed Tenant #1 was a 90 year old female admitted to the program on 4/14/22 with a diagnosis of hypertension and chronic pain. Tenant #1 was admitted with orders to continue using a 25 MCG/HR Fentanyl patch transdermally one time a day every three days for pain. Review of Tenant #1's Service plan dated 4/14/22 revealed Tenant #1 requested the program staff to administer all of her medications. Continued record review revealed the following: a. On 4/26/22 Tenant #1 was planning to go to a scheduled doctor's appointment but went to the ER instead. Physician's orders were to continue (1) 25 MCG/HR Fentanyl patch every 72 hours. b. On 4/29/22 Tenant #1 followed up with her PCP and was ordered to continue the (1) 25 MCG/HR Fentanyl patch at every 72 hours. c. On 5/06/22 Tenant #1 had received orders for one or two 25 MCG Fentanyl patches every three days PRN. If too sedated use only one Fentanyl 25 MCG/HR patch. d. On 5/09/22 Tenant #1 had gone to the ER for constipation. Tenant #1 was given a list of medications they were to discuss with their primary care provider. Tenant #1's Fentanyl patch every 72 hours was Included on the list. e. On 5/13/22 Tenant #1 went to the ER with her family and was diagnosed with a Fracture,	A 285		

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A 285	Continued From page 2	A 285		

thoracic vertebra, compression. The ER doctor ordered Tenant #1 to increase the Fentanyl patch to 50 MCG and to see her PCP in 4-5 days for a recheck.

f. On 5/19/22 Tenant #1 and her daughter followed up with her PCP per orders from the ER doctor on 5/13/22. The doctor observed and noted Tenant #1 wore only the one 25 MCG/HR Fentanyl patch staff applied earlier in error instead of the two as ordered at the time. The PCP noted the Tenant #1's pain was well controlled and they would not need to increase her Fentanyl patch to 50 MCG/HR. The Fentanyl 25 MCG/HR transdermal patch every 72 Hours was continued. The program reported they had not been made aware of this follow up visit and had not noted the order moving from the (1) 50 MCG/HR Fentanyl patch back to 25 MCG/HR. The Program continued to administer the Fentanyl at two patches every three days until running out on 5/28/22. The pharmacist could not fill the order as it was too early.

g. On 7/21/22 at 11:57a.m. the Clinical Care Specialist/Staff D noted the program had not received a copy of the 5/19/22 orders from Tenant #1's visit to her PCP.

When interviewed on 7/20/22 at 2:41p.m. the Pharmacist, responsible for filling the Fentanyl patch, revealed they had not seen the 5/13/22 order written by the emergency room physician. The pharmacist said if they had seen the script they would have filled it as written at a 50 MCG patch instead of the 25 MCG patch. The pharmacist reported they sent 10 Fentanyl 25 MCG/HR Transdermal patches on April 15, 2022 and refilled 10 more Fentanyl patches on May 13 for a 30 day supply each fill at every three days or

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72 hours.

Review of Tenant #1's Medication Administration Record for May 2022 revealed the 5/13/22 order was added to the MAR with a start date of 5/16/22. The order was noted by the Program nurse Staff C as Fentanyl Patch 72 hour 25 MCG/HR Apply (2) patches transdermally every 72 hours for pain and remove per schedule. MAR review revealed the two patches had been applied on 5/16/22, 5/19/22, 5/22/22, 5/25/22 and on 5/28/22. On 5/19/22 staff noted on the MAR that two patches had been administered. However, Controlled Drug Record review revealed only the one patch was applied on 5/19/22 in error instead of the two patches as ordered and as noted on the MAR.

On 7/20/22 at 1:40p.m. the Clinical Care Specialist confirmed this finding.

When interviewed on 7/21/22 at 9:08a.m. interview with the Program nurse/Staff C revealed the 5/13/22 Fentanyl order for 50 MCG had been sent to her and she should have followed up on it the next day and did not. Staff C said she should have had the order sheet for 5/13/22 faxed to the pharmacist and he would have taken from there and contacted the ER doctor for the electronic script to have it filled. Staff C confirmed she had put the (2) 25 MCG patches to equal 50 MCGs on the MAR but did not know the patches had run out. Staff C confirmed Tenant #1's PCP called her and said her dictation was her order period. Staff C confirmed they had not gotten the dictation back from the 5/19/22 visit and added the family was not very good at giving the facility documentation from those visits.

When interviewed on 7/21/22 at 12:33p.m.

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A 285	Continued From page 4 Tenant #'1s daughter confirmed she tookTenant #1 to the appointment on 5/19/22. The daughter could not recall if she had directly handed the orders to the Program Director or not when returning to the Program. The daughter added she thought the Doctor would also dictate and send that to the Program as well. Review of the Medication Review Report revealed Tenant #1's Fentanyl patch was noted as 25 MCG/HR, two patches trandermally every 72 hours for pain and remove per schedule. Tenant #1's PCP signed the report on 6/07/22 and lined out the 2 patches and reversed it back to (1) patch noting this was never prescribed as such by this provider. On 6/22/22 Tenant #1's PCP discontinued the use of the Fentanyl patch. The family reported Tenant #1 was more alert without the use of the Fentanyl patches. The PCP noted Tenant #1's family reported on 6/10/22 the Program's CNA removed the Fentanyl patch dated 5/28/22. Tenant #1 had worn a Fentanyl patch dating back to 5/28/22.	A 285		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by:	A 345		

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A 345	Continued From page 5 Based on record review and interview, the Program failed to ensure an employee's documented history of delegations concerning an employee's working on the floor with tenants were maintained on file. As a result, it could not be determined what a staff person's training on personnel cares consisted of and/or how much training staff had when asked to work the floor with tenants. Findings include: On 7/18/22 at 4:07p.m. interview with Staff B revealed Staff B was originally hired by the Program to work as a Receptionist/Scheduler. Three weeks later Staff B said she was asked to work the floor doing direct care. Staff B reported she had worked for three days and was put on the floor. Staff B reported she was told to use the IPAD but was never taught how to use it. Staff B reported she had to teach herself. On 7/20/22 at 10:38a.m. personnel record review revealed Staff B was hired by the Program to work as a receptionist on 6/07/21 and Terminated on 9/08/21. Record of Staff B's delegations concerning working with the Tenants of the Program could not be located. On 7/20/22 at 2:35 the Program Director confirmed Staff B's personnel file could not be located. The Director reported she thought Staff B had taken her file with her. Note the Director was able to obtain record of Staff B's background checks, Dependent Adult Abuse training and food safety training along with the required training in Relias.	A 345		