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 08/19/2024 |

| 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 |
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| A 000 | Initial Comments<br><br>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.<br><br>Number of tenants without cognitive impairment: 27<br>Number of tenants with cognitive impairment: 11<br>Total census: 38<br><br>There were no regulatory insufficiencies cited during the investigation of Complaint 119286-C.<br><br>The following regulatory insufficiencies were cited during the investigation of Complaint 118702-C. | A 000 | The POC is attached | |
| A 115 | 481-67.2(1)b Program Policies and Procedures<br><br>67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:<br><br>b. An incident report shall be in detail and shall be provided on an incident report form.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the program failed to ensure incident reports were completed in detail for 1 of 4 tenants reviewed (Tenant #1). Findings include: | A 115 | | |

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

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| A 115 | Continued From page 1<br><br>On 7/23/24 at 12:20 p.m. the Director of Health and Wellness reported Tenant #1 fell in her apartment on 2/1/24 at 9:30 p.m. The tenant was taken to urgent care the next day by her family due to bruising on the arm.<br><br>On 8/14/24 review of an incident report concerning Tenant #1's fall on the evening of 2/1/24 revealed the date and time of the incident was missing. Staff C documented she was called to the tenant's room by another staff. Tenant #1 was laying halfway on her back. She evaluated the tenant, checked her range of motion and helped her into bed. According to the tenant, she had missed a step. The report indicated the tenant had no injuries. The report was signed by Staff C on 2/3/24.<br><br>The time the incident occurred was later determined by the facility on 2/02/24 during an internal investigation completed as the tenant was noted to have a bruised arm.<br><br>On 8/15/24 at 3:40 p.m. the Provisional Administrator confirmed these findings. | A 115 | | |
| A 150 | 481-67.2(3) Program Policies and Procedures<br><br>67.2(3) The program shall follow the policies and procedures established by the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the program failed to follow established policies and procedures regarding incident reports and medication management regarding 2 of 4 tenants | A 150 | | |

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| A 150 | Continued From page 2<br>reviewed (Tenant #1, #2). Findings include:<br><br>1. On 7/23/24 at 12:20 p.m. the Director of Health and Wellness reported that on 2/3/24 it was discovered 2 tenants received each other's medications in error on the morning of 2/1/24 (Tenants #1, #2). In addition, Tenant #1 fell in her apartment on 2/1/24 at 9:30 p.m. The tenant was taken to urgent care the next day by her family due to bruising on her arm. The Director did not indicate she felt there was a correlation between the two incidents.<br><br>On 8/14/24 review of the incident report concerning Tenant #1's fall on the evening of 2/01/24 revealed the report was signed by Staff C on 2/3/24.<br><br>On 8/14/24 a review of the Incident Report policy revealed the staff person who discovered the incident was to complete an incident report by the end of their shift. Staff C did not complete the incident report until 2 days after the incident occurred.<br><br>2. Review of the Medication Management policy on 8/14/24 revealed medication errors for a wrong drug should be immediately reported to the Director of Health and Wellness. The Director of Health and Wellness or designee would notify the medical provider, responsible party, perform interventions as directed, complete incident reports and document the medication error, interventions and notifications in the tenants' record.<br><br>According to the Director of Health and Wellness, Tenants #1 and #2 received each others medications on the morning of 2/1/24. Tenant #1 received Quetiapine Fumarate (psychotropic) | A 150 | | |

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| A 150 | Continued From page 3<br>meant for Tenant #2, and Tenant #2 received Tenant #1's acid reflux medication. The medications were administered in error by Staff F.<br><br>No incident reports regarding these medication errors as stated in the Medication Management policy could be located. It should be noted that a medication error is not included in the Incident Report policy as something for which a report was needed. In addition, there was no documentation in either tenant's file of the med error or interventions completed as outined in the policy.<br><br>On 7/23/24 at 11:40 a.m. interview with Tenant #1's daughter revealed the family had not been notified of the medication error by the Program. She learned of the error from hospice.<br><br>3. On 8/15/24 at 3:40 p.m. the Provisional Administrator confirmed these findings. | A 150 | | |
| A 285 | 481-67.5(2)f(4) Medications<br><br>67.5(2) Each program shall follow its own written medication policy, which shall include the following:<br><br>f. When medications are administered traditionally by the program:<br><br>(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the | A 285 | | |

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| A 285 | Continued From page 4 | A 285 | | |

program failed to administer medications and treatments as prescribed for 2 of 4 tenants reviewed (Tenants 1, #2). Findings include:

1. On 7/23/24 at 12:20 p.m. the Director of Health & Wellness reported an incident that occurred on the morning of 2/01/24. The incident involved Tenant #2's psychotropic medication (Quetiapine Fumarate) being administered to Tenant #1 and Tenant #1's acid reflux medication (Famotidine) being administered to Tenant #2 in error. Review of the tenants' EMARs (electronic medication administration record) revealed Staff F noted he administered Tenant #1 her Famotidine 20 mg. tablet on the morning of 2/2/24 and Tenant #2 her Quetiapine Fumarate on the morning of 2/1/24 and 2/2/24. It was later determined by the Provisional Administrator on the morning of 2/3/24 that the medication bubble packs were in the wrong apartments. Tenant#1's Famotidine bubble pack was found in the medication drawer in Tenant #2's apartment. Tenant #2's Quetiapine Fumarate bubble pack was found in the medication drawer in Tenant #1's apartment. All of the other medication bubble packs for these two tenants were in the correct apartments.

The Provisional Administrator was present during this interview with the Director of Health and Wellness. She stated when she talked to Staff F after discovering the med error and the meds in the wrong apartments, he felt it was the person who did the medication change over who was responsible for the error. The Provisional Administrator confirmed the monthly medication change over (putting the new monthly medications in each tenant's apartment) had been completed on the evening of 1/31/24. It was first believed Staff G did the medication change over that day, but she denied doing it.

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| A 285 | Continued From page 5<br><br>When interviewed on 8/14/24 at 1:46 p.m. Staff G did not recall doing the medication change over on 1/31/24 and denied any wrongdoing. She thought Staff F should have realized he was administering the wrong medications when giving them on 2/1/24.<br><br>Review of the Medication Administration policy on 8/14/24 revealed staff were to identify the correct resident, remove the medication from the original container, and place the medication in a med cup or hand as ordered by the prescriber. Staff were then to complete the documentation on the resident's EMAR. The person administering the medication was to initial and sign the medication was given.<br><br>On 7/23/24 record review revealed Tenant #1 was admitted to the Program on 12/18/17 and moved to the secured memory care unit on 12/28/23. Review of Tenant #1's service plan revealed medication administration had been delegated to the program on 8/2/18. Physician's orders review revealed an order dated 1/02/24 for Tenant #1 to take one 20 mg. tablet of Famotidine one time daily by mouth for GERD (gastroesophageal reflux disease). Tenant #1's EMAR revealed an administration time of 9:00 a.m.<br><br>On 7/23/24 record review revealed Tenant #2 suffered late onset Alzheimer's disease with a move in date to the secured memory care unit of 1/02/24. Tenant #2's service plan noted program staff were responsible for her medication administration. Physician's orders dated 1/15/24 included 37.5 mg. of Quetiapine three times daily. The EMAR revealed administration times of 8:00 a.m., 2:00 pm. and 8:00 p.m. | A 285 | | |

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| A 285 | Continued From page 6<br><br>On 7/23/24 at 4:45 p.m. the Provisional Director confirmed on the morning of 2/03/24 she went to get Tenant #1's medication for her. She was unable to find the bubble pack for her Famotidine Tablet 20 mg. in Tenant #1's medication drawer. However she found Tenant #2's morning bubble pack of Quetiapine 37.5 mg. medication stored in the drawer. The pill for 8:00 a.m. had been popped out. The tenant's EMAR revealed the Famotidine was noted as administered to Resident #1. After finding Tenant #2's card of Quetiapine in Tenant #1's medication drawer she went to Tenant #2's medication drawer and found Tenant #1's Famotidine bubble pack card. After reviewing the documentation she found that Staff F had documented that he administered all of Tenant #2's morning medication and documented he administered all of Tenant #1's morning medication. Staff F appeared to have given Tenant #2's Quetiapine to Tenant #1 one time on the morning of 2/01/24 and Tenant #1's Famotidine to Tenant #2 on 2/01/24 and on 2/02/24. None of Tenant #1's morning medication had not been administered to her on the morning of 2/02/24. Progress notes review revealed Staff F noted Tenant #1 slept all morning, medications not given.<br><br>2. On 8/15/24 record review revealed Tenant #1 returned from urgent care on 2/02/24 with a diagnosis of a right distal radius fracture that required the need to wear a right arm splint and sling. A physician's order revealed staff was to be applied under the right elbow 20 minutes 5x/day.<br><br>Review of Tenant #1's February 2024 EMAR the order read to ice 20 minutes under the right elbow 1 time a day for five days. As a result, the icing was not completed as ordered. | A 285 | | |

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| A 285 | Continued From page 7<br>On 8/15/24 at 10:31 a.m. the Provisional Administrator confirmed the icing of the right elbow was not documented as having been completed 5x per day for 20 minutes each time. The physician's treatment orders had not been noted properly on the EMAR. | A 285 | | |
| A 145 | 481-69.22(3) Evaluation of Tenant<br><br>69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to evaluate a tenants's functional, cognitive and health status for 1 of 1 tenants reviewed with a significant change in condition (Tenant #1). Findings include:<br><br>1. On 7/23/24 at 12:20 p.m. the Director of Health and Wellness reported an incident when Tenant #1 fell in her apartment on 2/1/24 at 9:30 p.m. The tenant was taken to urgent care the next day | A 145 | | |

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| A 145 | Continued From page 8 | A 145 | | |

by her family due to bruising on the arm.

On 7/23/24 at 4:45 p.m. review of the documentation provided by the Provisional Administrator revealed on the morning of 2/02/24 at 11:15 a.m. she went to wake Tenant #1, who was still in bed, for lunch. At that time, Tenant #1 was reported to be soaking wet with urine and was complaining of pain in her right wrist. Tenant #1's right wrist was noted as very bruised and swollen. The bruising was also noted to run halfway up her right arm. Tenant #1's family was notified and they took her to urgent care by her family. She later returned to the program with a diagnosis of a urinary tract infection and a a right distal radius fracture that required the need to wear a right arm splint and sling.

A functional, cognitive and health status evaluation regarding these significant changes could not be located.

On 8/15/24 at 10:38 a.m. the Provisional Administrator confirmed the evaluations had not been completed.

2. On 8/15/24 at 2:26 p.m. progress notes review revealed on 10/03/23 the tenant was started on Cephalexin oral capsule 500 mg. by mouth two times a day for seven days for a wound on the buttocks. On 10/06/23 the gluteal folds were assessed by the Director of Health & Wellness and a small open wound remained. Tenant #1 was instructed to not sit for long periods of time, and to get up and walk every two hours to take pressure off of her buttocks.

A functional, cognitive and health status evaluation regarding the significant change concerning the open wound on her buttocks could

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| A 145 | Continued From page 9<br>not be located.<br><br>On 8/15/24 at 2:35 p.m. the Provisional Administrator confirmed the evaluations had not been completed. | A 145 | | |
| A 370 | 481-69.26(3)a Service Plans<br><br>69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.<br><br>a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the program failed to ensure service plans updated following significant change had been signed and dated by all parties for 3 of 4 tenants reviewed (Tenants #1, #3., #4). Findings include:<br><br>1. On 8/15/24 record review revealed Tenant #1 had an updated service plan dated 2/03/24 following return from urgent care with a diagnosis of a right distal radius fracture that required the need to wear a right arm splint and sling. Tenant #1's updated service plan had not been signed and dated.<br><br>On 8/15/24 at 10:38 a.m. the Provisional Administrator confirmed this finding.<br><br>2. On 8/19/24 record review revealed Tenant #3 | A 370 | | |

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| A 370 | Continued From page 10<br>had started hospice and physical therapy services following her return from the hospital on 7/26/24. The updated service plan had not been signed and dated.<br><br>On 8/19/24 record review revealed Tenant # 4 had a change of condition completed on 5/03/24 following her return to the facility after her hospitalization. The updated service plan had not been signed and dated.<br><br>On 8/19/24 at 11:22 a.m. the Provisional Administrator confirmed these findings. | A 370 | | |

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| **Tag #1** | 481-67.2(1)b Program Policies and Procedures<br><br>67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:<br><br>b. An incident report shall be in detail and shall be provided on an incident report form. | **A115** | **What initial correction was made?**<br><br>DHW and/ or designee will be educated on policy DP04 Incident Reporting by 11/26/2024 by Regional Director of Resident Care. | **How will we ensure and maintain compliance going forward?**<br>DHW and/ or designee will review all incident reports bi-weekly for eight weeks to ensure accuracy and compliance. | Implementation Date: 10/25/24<br><br>Completion Date: 12/24/2024<br><br>Responsible Party: DHW or designee |
| **Tag #2** | 481-67.2(3) Program Policies and Procedures<br><br>67.2(3) The program shall follow the policies and procedures established by the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the program failed to follow established policies and procedures regarding incident reports and medication management regarding 2 of 4 tenants | **A150** | **What initial correction was made?**<br><br>DHW and/or designee conducted a mandatory training for all staff on our incident reporting policy and the requirement to complete reports by the end of their shift.<br><br>DHW Updated the Medication Management policy to explicitly include the requirement for staff to report medication errors immediately and ensure that the Director of Health and Wellness or designee follows the protocol for notification and documentation. This was completed on 10/25/24. Training was provided on the policy and procedure changes on 10/25/24. | **How will we ensure and maintain compliance going forward?**<br><br>DHW and/or designee will audit incident reports bi-weekly for 90 days to ensure compliance with the reporting timeframe.<br><br>DHW to audit medication errors and report bi-weekly for 90 days and as needed thereafter. | Implementation Date: 10/25/2024<br><br>Completion Date: 112/20/2024<br><br>Responsible Party: DHW or designee |

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| **Tag #3** | **481-67.5(2)f(4) Medications 67.5(2)**<br>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.<br><br>This REQUIREMENT is not met as evidenced by: A 285 Based on interview and record review the Program failed to ensure tenants received medications as prescribed. This pertained to 2 of 4 tenants reviewed. | **A285** | **What initial correction was made?**<br><br>All Medication Delegated staff received training on 10/25/24 regarding MAR documentation, notifying nurses when medications are unavailable and re-ordering medications through pharmacy. | **How will we ensure and maintain compliance going forward?**<br><br>Audit three residents 1x weekly x 4 weeks to ensure medications are available and document correctly. Then utilize as needed going forward. | Implementation Date: 11/26/2024<br><br>Completion Date: 11/30/2024<br><br>Responsible Party: DHW or designee |
| **Tag #4** | 481-69.22(3) Evaluation of Tenant<br><br>69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. | **A145** | **What initial correction was made?**<br><br>DHW will be educated on Policy AS01-Asessments by 11/26/24 conducted by the Division Director of Resident Care. The resident Assessment are completed/updated:<br>a. Prior to move-in.<br>b. 30 days after move-in.<br>c. Every six (6) months.<br>d. Whenever there is a significant change in resident status. | **How will we ensure and maintain compliance going forward?**<br><br>DHW and/or designee will audit four resident's charts once per week for eight weeks for changes to ensure all residents residing in the community have functional, cognitive and health status evaluations and service plans documented accurately. Once the initial audit is completed, resident charts will be audited on a quarterly basis. | Implementation Date: 11/26/2025<br><br>Completion Date: 11/30/2024<br><br>Responsible Party: Director or designee |

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| **Tag #5** | 481-69.26(3)a Service Plans<br><br>69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.<br><br>a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the program failed to ensure service plans updated following significant change had been signed and dated by all parties for 3 of 4 tenants reviewed (Tenants #1, #3., 4). | **A370** | **What initial correction was made?**<br>DHW will be educated on Policy AS05-Asessments by 11/26/24 by the Division Director of Resident Care.<br><br>Service Plans are created/updated: (1)<br>a. Prior to or at the time of move-in.<br>b. 30 days after move-in.<br>c. Every six (6) months.<br>d. Whenever there is a significant change in resident status.<br><br>The assessment system was updated to trigger assessments and service plans prior to moving in, 30 days within move in and every 6 months. | **How will we ensure and maintain compliance going forward?**<br><br>DHW or designee will audit four residents' charts once per week for eight weeks to ensure all residents residing in the community have a service plan that is individualized based on the resident's needs and preferences. Once the initial audit is completed, resident charts will be audited on an ongoing basis quarterly. | Implementation Date: 11/25/2024<br><br>Completion Date: 11/30/2024<br><br>Responsible Party: Director or designee |

*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.*

Compliance Date: 11/30/2024