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
	S0310	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - TIMBER RIDGE	#2 OAK RIDGE ROAD OTTUMWA, IA 52501

(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. Number of tenants without cognitive impairment: 22 Number of tenants with cognitive impairment: 1 Total census: 23 The following regulatory insufficiencies were cited during the investigation of Incident #117324-I.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide adequate care following a medication error for 1 of 1 tenants reviewed (Tenant #1). Findings follow: Review of Tenant #1's record on 6/24/24 revealed a history of severe peripheral neuropathy, obesity and Parkinson's disease. Tenant #1 generally got around via her wheelchair. A medication error report form identified Tenant	A 160	The Plan of Correction is attached	

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

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A 160	Continued From page 1	A 160		

#1 received the wrong medications on 11/30/23 at 8:00 PM. Staff A incorrectly administered the following medications: Diphenhydramine, Ferrous Sulfate, Lamotrigine, Mirtazapine, Pramiprexole, Quetiapine and Clonazepam. The Registered Nurse (RN), noted the medications possibly caused excessive drowsiness and a fall out of bed.

A post-fall incident report and investigation tool, completed by Staff C, noted on 12/1/23 at 2:55 AM, she received a page from Tenant #1 and found her on the bedroom floor next to her bed. Tenant #1's head was between her bed and side table. She reported head and back pain. Tenant #1 stated she rolled out of bed. Staff C determined Tenant #1 was visibly unable to move safely. Staff C contacted the paramedics so Tenant #1 could be assessed at the hospital. When Tenant #1 was lifted by the emergency medical services, she was bleeding from the back of the head and left cheek. The hospital patient health summary from 12/1/23 provided Tenant #1 with diagnoses of facial contusion, fall and weakness.

Tenant #1 met with her PCP on 12/5/23. The PCP noted Tenant #1 had a fall on 12/1/23. Tenant #1 fell out of bed and ended up with a hematoma to the left occipital area and left cheek. The fall occurred after receiving the wrong medications, including multiple sedative hypnotics. Tenant #1 noted she felt very foggy at the time of her fall and was not able to maintain her balance. She also had feelings of lethargy the next day.

The Registered Nurse documented on 12/5/23 on the Post-fall incident report and investigation tool the root cause of the fall was due to Tenant #5 receiving the wrong medications.

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A 160	Continued From page 2	A 160		

Staff A provided a written statement, dated 12/6/23, of how the medication error occurred. Staff A wrote she popped medication out of the bubble pack and placed the pills in a medication cup for Tenant #2. This tenant was not available, so Staff A locked the pills in the medication cart drawer and moved on to the next apartment. Staff A put the medication for Tenant #1 in a medication cup and entered her apartment. Tenant #1 was in the bathroom. Staff A also put this cup of medication into the medication cart. When Staff A returned to Tenant #1's apartment to administer her medication, she gave Tenant #1 the medication which was prescribed to Tenant #2. Staff A did not return a call for an interview during the time period in which the incident was investigated.

On 6/27/24 at 10:15 AM, Staff B recalled Staff A approached her and was really upset and frustrated because she gave medication to the wrong person. Staff A said she called the Director and RN about this. Staff B did not ask any other questions about the situation, because she believed the others (Staff A, the Director and RN) were handling things. Staff A stormed out after she reported the incident to Staff B. Staff B did not learn the name of the tenant who was given improper medication prior to Staff A's departure. Staff B remained at work about another hour before Staff C's arrival at the program. Staff B told Staff C about a tenant receiving the wrong medication. Staff C asked the name of the tenant, but Staff B did not know who it was at that time. Staff B stated each time there was a medical incident, staff were to fill out a form with the tenant's vitals and range of motion every hour. This was not done for Tenant #1. After Staff A left the building, Staff B found herself wondering

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A 160	Continued From page 3	A 160		

which tenant received the incorrect pills.

On 6/27/24 at 10:30 AM, Staff C commented when she came into work on 11/30/23 she was told Staff A gave one tenant another tenant's medication, although Staff B did not know who it was. Tenant #1 paged her early in the morning on 12/1/24. She found Tenant #1 laying on the floor next to her bed. The side table was about a foot from the bed. Her head was wedged in there. Staff C called the EMTs and RN. Staff C was not aware Tenant #1 received another tenant's medication and did not provide the EMTs this information. If Staff C had known Tenant #1 got the wrong medication, she would have checked on Tenant #1 more often through the night and taken her vitals. She also would have told the EMTs about the medication error.

On 6/27/24 at 9:40 AM the RN reported she received a call from Staff A about the medication error. The RN told Staff A she needed to monitor Tenant #1 to make sure she didn't have any side effects from the medication she received. The RN told Staff A to put Tenant #1 on "vitals." This meant staff were to collect Tenant #1's vital signs every hour and document it on a flow sheet. This was not done. The RN called Tenant #1's PCP and learned he was not on-call. The RN did not tell the on-call doctor about Tenant #1 receiving the wrong medication because she believed the medication she had received was in the same category as what she was prescribed and because the on-call doctor was not familiar with Tenant #1. The RN reported she did not believe she was aware Tenant #1 had a fall early in the morning on 12/1/24 until she came into work later that day. She denied receiving a call from Staff C, but thought perhaps she received a text. The RN assessed Tenant #1 the morning of 12/1/24 and

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A 160	Continued From page 4 called the PCP about the fall. The RN said she trained staff not to get medication out for tenants until she was sure the tenant was available. The RN stated it would have been important for the EMTs and emergency room staff to know Tenant #1 received the incorrect medication following her fall. On 6/27/24 at 8:40 AM, Tenant #1 reported being frustrated Staff A knew about the medication error on 11/30/24 by 8:00 PM, but didn't inform her at the time. In addition, Tenant #1 said she was not told about the error until the middle of the following week. Tenant #1 reported she felt drugged when she got up to go to the bathroom and fell on 12/1/24. Tenant #1 was also upset the hospital was not informed she received the wrong medication. Staff A did not report information about the tenant involved in the medication error prior to leaving the building. Staff A, B and C did not complete hourly vital checks on Tenant #1 following the medication error. Either the RN did not inform Staff C of the medication error when she was informed of the fall or Staff C failed to call the RN. The EMTs did not know about the medication error. On 6/27/24 at 10:50 AM, the Director confirmed staff should have called the RN and followed her directions. Tenant #1 should have been checked on every 1-2 hours. Staff A should have documented the medication error in the communication log and filled out a medication error report.	A 160		

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A 285	Continued From page 5	A 285		
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 medications as prescribed resulting in a fall and emergency room visit for 1 of 1 tenants reviewed (Tenant #1). Findings include: Record review on 6/27/24 revealed Tenant #1 had a November Medication Administration Record listing her medication. Staff were to administer Tenant #1 the following medications each evening: Atorvastatin, Melatonin, Nortriptyline, Tamsulosin, Eliquis, Nucynta ER, Pantoprazole, Pregabalin, Primidone and Carbidopa/Levodopa. A medication error report form identified Tenant #1 received the wrong medication on 11/30/23 at 8:00 PM. Staff A administered the following medications: Diphenhydramine, Ferrous Sulfate, Lamotrigine, Mirtazapine, Pramiprexole, Quetiapine and Clonazepam. The Registered Nurse (RN) noted the medications could possibly cause excessive drowsiness and a fall out of bed.	A 285		

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A 285	Continued From page 6	A 285		

A post-fall incident report and investigation tool, completed by Staff C, noted on 12/1/23 at 2:55 AM, she received a page from Tenant #1 and found her on the bedroom floor next to her bed. Tenant #1's head was between her bed and side table. She reported head and back pain. Tenant #1 stated she rolled out of bed. Staff C determined Tenant #1 was visibly unable to move safely. Staff C contacted the paramedics so Tenant #1 could be assessed at the hospital. When Tenant #1 was lifted by the emergency medical services, she was bleeding from the back of the head and left cheek. The hospital patient health summary from 12/1/23 provided Tenant #1 with diagnoses of facial contusion, fall and weakness.

Tenant #1 met with her primary care provider (PCP) on 12/5/23. The PCP noted Tenant #1 had a fall on 12/1/23. Tenant #1 fell out of bed and ended up with a hematoma to the left occipital area and left cheek. The fall occurred after receiving the wrong medication, including multiple sedative hypnotics. Tenant #1 noted she felt very foggy at the time of her fall and was not able to maintain her balance. She also had feelings of lethargy the next day.

The Registered Nurse documented on 12/5/23 the root cause of the fall was due to Tenant #5 receiving the wrong medication.

Staff A provided a written statement, dated 12/6/23, of how the medication error occurred. Staff A wrote she popped medication out of the bubble pack and placed the pills in a medication cup for Tenant #2. This tenant was not available, so Staff A locked the pills in the medication cart drawer and moved on to the next apartment. Staff A put the medication for Tenant #1 in a

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A 285	Continued From page 7 medication cup and entered her apartment. Tenant #1 was in the bathroom. Staff A also put this cup of medication into the medication cart. When Staff A returned to Tenant #1's apartment to administer her medication, she gave Tenant #1 the medication which was prescribed to Tenant #2. Staff A did not return a call for an interview during the time period in which the incident was investigated. On 6/27/24 at 9:40 AM, the RN stated Staff A had not administered medications for very long at the program. The RN said she drilled all staff from day one they should never pop pills out of the bubble packs until they were sure a tenant was available. On 6/27/24 at 10:50 AM, the Director confirmed Tenant #1 was not administered the correct medication.	A 285		

Plan of Correction

Good Samaritan Society- Timber Ridge

#2 Oak Ridge Rd

Ottumwa, IA 52501

F00 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth or facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

ID PREFIX TAG - A160: 481-67.3(2) Tenant Rights

All staff were provided education on 12/18/23 on tenant rights to receive care, treatment and services which are adequate and appropriate and medication management/administration. The education included communication log process, the importance of communicating important tenant changes between shifts through use of communication logs and also through face to face shift report. On July 1, 2024 a new communication log process was put in place.

Timber Ridge is performing weekly audits to ensure that the new communication log process is operational and ensure that tenant changes are communicated through the new process for three months and will report to QAPI. Timber Ridge will also have a follow-up staff education on 9/4/24.

Correction Date: 12/18/2023

ID PREFIX TAG- A285: 481-67.5(2)f(4) Medications

Following the incident on 12/1/23 the medication aide (staff A) was assigned medication administration: refresher course and was given a verbal re-education on the 6 rights: right tenant, right drug, right dose, right time, right route, right documentation. The verbal education included to check each and every medication three times to verify right tenant, right medication, right time and to always make contact, face to face, with the tenant prior to administering medications.

All staff were re-educated on the rights of medication management on 12/18/23. Timber Ridge also performed weekly audits of medication passes with random medication aides to ensure all rights of medication were being followed for three months and reported to QAPI.

Correction Date: 12/18/2023

8/15/24