STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165338	A. BUILDING _____ B. WING _____	C 09/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHGATE CARE CENTER	960 4TH STREET NW WAUKON, IA 52172

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 10/10/24 The following deficiency resulted from the investigation of complaint #123565-C conducted September 20, 2024 to September 22, 2024. Complaint #123565-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to give 1 of 3 residents the correct medications and inadvertently gave him another residents medications that included anti-psychotic medication resulting in over sedation and admission to the hospital for observation (Resident #1). The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 8/15/24 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented he did NOT take anti-psychotic medication and had no neurological diagnoses. The MDS also documented his psychiatric/mood disorder was	F 760		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jou Ann Wilkar — TITLE: Adm. — (X6) DATE: 10/8/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 depression. Record review of an Emergency Room (ER) note dated 9/18/24 for Resident #1 documented he received the following wrong medications at the facility: Zonisamide 100 milligrams (mg) - anti-convulsant Zofran 4 mg - anti-emetic Sucralfate 1 gram (g) - ant-acid Seroquel 200 mg - anti-psychotic Propranolol 20 mg - beta blocker Tylenol 1000 mg - analgesic The ER note also documented he was minimally arousal all afternoon according to family and the facility, and had a blood sugar of 52. He was sedated likely due to the Seroquel he received in error, Poison Control suggest six (6) hours of observation. His low hypoglycemia (blood sugar) was likely due to being sleepy and sedated. Plan is to admit to the Hospital for accidental Seroquel administration and hypoglycemia. The facility will admit him for close monitoring and anticipated metabolism of the inadvertently provided Seroquel. Record review of a document titled, Action Plan for Medication Event on 9/18/24 instructed the following: a. Resident was assessed and physician was notified. b. A full investigation was completed. c. Effective immediately a sign will be placed on the medication cart while medication pass is in progress to deter interruptions. 4. On 9/19/24, re-education of the six (6) rights of medication pass was provided to all nurses and CMA's. 5. Medication Pass audits will be completed two (2) times a week on all shifts for one (1) month.	F 760		

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F 760	Continued From page 2 The frequency of audits thereafter will be determined by outcomes. Record review of a Progress Note dated 9/19/24 at 3:02 PM by Resident #1 Doctor documented, he had a minor event on 9/18/24 and given several wrong medications which were intended for another resident. Most notable was an anti-psychotic Seroquel 200 mg. He ultimately settled in for the afternoon and slept, which was expected. He did experience an episode of hypoglycemia that was not directly related to the medication. However, Resident #1 is a gentleman who typically snacks all afternoon, and he did not do that, but rather slept, and that led to hypoglycemic episode that resulted in his transport to the emergency department for evaluation. It was a predictable event, not directly caused by the medication, but caused by his sleeping. During an Interview on 9/20/24 at 6:40 PM with Resident #1 revealed he recently went to the hospital because his blood sugars tanked. He informed everything went fine and he got to come back home to the facility. During an interview with the Administrator on 9/20/24 at 6:47 PM revealed Resident #1 was given the wrong residents medications this week on 9/18/24 and they sent him the hospital for evaluation and he ended up staying the night for observation. During an interview on 9/20/24 at 7:48 PM with the Director of Nursing revealed Staff A, Certified Medication Aide (CMA) received an upsetting personal call prior to the noon medication pass on 9/18/24 and she did all her correct checks but	F 760		

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F 760	Continued From page 3 walked to the wrong resident. She informed she immediately put an action plan in place so this would not occur again. During an interview with Staff A, (CMA) on 9/22/24 at 12:58 PM informed she was on break and received a phone call that was upsetting, and got distracted and accidentally gave Resident #1 another resident's medications. She informed as soon as she got back to the cart she identified the error right away and his Doctor and the DON were updated. She informed after this happened she had a conversation with the DON about how it could have been prevented.	F 760		

October 8, 2024

Northgate Care Center
960 4th St. N.W.
Waukon, IA 52172

Plan of Correction for Survey Completed: 9/22/24

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction date: 10/10/24

F760 Residents are Free Significant Med Errors
For the required plan of correction, the facility submits the following:

1. Nurses receive extensive education and training of principles and procedures of safe medication administration practices through accredited nursing programs prior to receiving their licensure. Safe medication administration procedures and facility-specific processes are included in the orientation of newly employed nurses and certified medication aides (CMAs) and competency is reviewed on a regular basis thereafter. Staff competency of medication administration is evaluated at least annually by quality assurance nurses and/or pharmacists.
2. The facility has systems designed to minimize medication errors as well as systems that require investigation and corrective action to prevent recurrence. On 9/19/24, a sign was placed on the medication cart progress to deter interruptions of the nurse passing medication and will remain in place while medication pass is in progress. On 9/19/24, re-education of the new process and of the 6 rights of medication administration was provided to nurses and CMA's.
3. Through the facility's quality assurance process, the Director of Nursing Services or their Designee will audit the accuracy of Medication Administration 2 times a week on all shifts for 1 month. The frequency of audits thereafter will be determined by the outcomes.