STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD367 HFD	A. BUILDING _____ B. WING _____	09/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	1831 EAST KANESVILLE BLVD COUNCIL BLUFFS, IA 51503

(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: 0 Number of tenants with cognitive disorder: 17 TOTAL Census of Assisted Living Program for People with Dementia: 17 The following regulatory insufficiencies were cited during the Investigation of Complaint #75062-C	A 000	See attached POC 10/15/18	
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications 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 according to doctor's orders for 1 of 3 tenants reviewed (Tenant #1). Findings follow: Record review revealed Tenant #1 was admitted on 9-14-17. Review of her Service Plan dated 11-29-17 revealed the Program administered her medications.	A 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 147	Continued From Page 1 Continued record review on 9-18-18 revealed Tenant #1's Medication Administration Record (MAR) dated October 2017 reflected she received citalopram 10 milligrams (mg) one time per day. The dosage increased on 10-17-17 to 20 mg two times per day. Further review of Tenant #1's MAR dated December 2017 revealed citalopram was changed on 12-22-17 from 20 mg two times per day to 40 mg one time per day. Review of Physician Fax Communication dated 10-17-17 revealed an order for citalopram 20 mg two times per day signed by the Advance Practice Registered Nurse (APRN). Further review revealed no other communication from the APRN that approved the change in time of administration on 12-22-17. During an interview on 9-18-18 at 9:18 a.m. the Registered Nurse (RN) from the home health care agency stated that she was unable to locate any documentation for the medication change on 12-22-17. During an interview on 9-18-18 at 9:31 a.m. the APRN stated she did not recall the specific order. She stated that she would have documented the change if she approved it over the phone with the Program. During an interview on 9-18-18 at 11:31 a.m. the RN stated she no longer worked at the Program. She remembered the family did not want Tenant #1 to take too many medications in the evening and changed the medication order so that she only took the medication in the morning. She stated she needed a doctor's order to make the change and did not know why one was not in the file. During an interview on 9-18-18 at 10:38 a.m. the	A 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 147	Continued From Page 2 Corporate RN confirmed this finding.	A 147		

COUNTRYHOUSE RESIDENCE *for memory care*

04118/18
✓ 11/9/18

15 October 2018

HEALTH FACILITIES

OCT 2 0 2018

Department of Inspections and Appeals
Attn: Linda Kellen
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Kellen:

On behalf of CountryHouse Residence in Council Bluffs, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report for the onsite visit on September 17 and 18, 2018. 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 insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Medications

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - The program will follow their Policy and Procedure for Medication administration (attached), including administering medications according to the physician orders.

2. What measures will be taken to ensure the problem does not recur.
    - The Nurse will do a secondary safety check on all medication orders entered into the eMAR by the pharmacy prior to activating them. This safety check will ensure all of the 5 rights of medications administration are an accurate reflection of the physician orders.

3. How the Program plans to monitor performance to ensure compliance.
- The Nurse will monitor medication administration orders and times by doing a random spot check of 5 residents weekly for 6 months.
- If an unsatisfactory pattern is noted during the random spot check, the nurse will make corrections immediately and follow the process for medication errors (attached).
- The nurse will report to the Administrator monthly her findings of the random monitoring.

4. The date by which the regulatory insufficiency will be corrected.
    - Effective immediately