V 12/24/19 OK 11/20/19

PRINTED: 10/29/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD375 HFD	A. BUILDING _____ B. WING _____	09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT BRIDGEWATER ALP/D	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

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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: 3 Number of tenants with cognitive disorder: 14 TOTAL Census of Assisted Living Program for People with Dementia : 17 The following regulatory insufficiencies were cited during the investigation of Complaint # 84315-C and Complaint # 84640-C:	A 000	See attached POC 11/28/19	
A 008	481-67.2(1)e Program Policies and Procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This Requirement is not met as evidenced by:	A 008		

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

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A 008	Continued From Page 1 Based on interview and record review, the Program failed to complete an incident report for 1 of 3 residents reviewed on two separate medication errors (Tenant #1). Findings include: On 9/16/19, a review of tenant records revealed the following: Tenant #1 was admitted to the Program on 8/20/18 with a diagnosis of Alzheimer's disease, hyperlipidemia, major depressive disorder, hypertension, anxiety, and insomnia. Tenant #1 had an order dated 6/4/19, for methadone 5 mg. The tablet was to be split in half, resulting in 2.5 mg given each night prior to bed. A review of hospice notes for Tenant #1 on 9/17/19 and an interview with Tenant #1's hospice nurse on 9/17/19 at 1:11 PM, revealed the following information: 1). On 6/24/19, the Assistant Director of Nursing (ADON) contacted hospice to report only having one dose of methadone left that would be administered that night. 2.) Hospice informed the ADON the methadone was supplied on 6/16/19 and seven 5 mg tablets were delivered for Tenant #1 from an emergency pharmacy due to it being last minute on a weekend. Seven tablets would have covered 14 days of medication. The ADON informed the hospice nurse that because staff were used to the tablets being delivered already cut in half, staff administered the tablets in whole form on several days which would have resulted in Tenant #1 receiving a double dosage of the methadone medication and would run out early. A comparison of the hospice notes and medication timeline on 9/17/19, revealed the resident would have received a double dosage of the methadone	A 008		

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A 008	Continued From Page 2 medication for 5 days out of the 14 days the resident should have been supplied with the medication. On 9/16/19 a review of incident reports revealed an incident report completed by the ADON on 6/25/19, indicated a 5 mg methadone tablet was mistakenly given to Tenant #1 which resulted in a double dose on the night of 6/24/19 instead of the ordered 2.5 mg order for methadone. The incident report was incomplete and did not reveal the full picture of the discussion held between hospice and the ADON on 6/24/19. Tenant #1 was given 5 double dosages not just one on 6/24/19. The doctor was notified on 6/24/19. Tenant #1 showed minor signs of sleepiness due to the medication error. A review of Tenant #1's medication administration record (MAR) revealed on 7/11/19, 7/12/19, 7/13/19 and 7/14/19, Tenant #1's order for 2.5 mg of methadone at bedtime had dropped off of the documentation record. Nurse's notes completed on 7/17/19 by the Director of Nursing (DON) revealed a notation Tenant #1 had not received her methadone dosage on 7/12/19 and 7/13/19 due to the medication being absent from the MAR. On 9/18/19 at 9:31 p.m. after review of Tenant #'s MAR, the Director of Nursing stated the methadone order for Tenant #1 was actually absent from the MAR on 7/11/19, 7/12/19, 7/13/19 and 7/14/19 resulting in four days without the medication. No side effects were noted. No incident report was completed on this medication error. A review of Program policies on 9/16/19 revealed the Incident Reporting policy contained the following information: "All accidents or unusual occurrences within Grand Living's building or on the premises that affect residents shall be	A 008		

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A 008	Continued From Page 3 reported as incidents, including allegations of dependent adult abuse." On 9/19/19 at 11:45 AM, the Director and the DON confirmed both the June medication error and the July medication error for Tenant #1 were not correctly documented on a printed incident report.	A 008		
A 038	481-67.5(6)c 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: c. The program shall maintain a list of each tenant ' s medications and document the medications administered. This Requirement is not met as evidenced by: Based on interview and record review, the Program failed to ensure all medications administered were documented on the medication administration record (MAR). This affected 1 of 3 tenants reviewed (Tenant #1). Findings include: On 9/16/19, a review of tenant records revealed the following: Tenant #1 was admitted to the Program on 8/20/18 with a diagnosis of Alzheimer's disease, hyperlipidemia, major depressive disorder, hypertension, anxiety, and insomnia. A review of Tenant # 1's MARs revealed the following open gaps in the documentation with no explanation of why the medication was not documented or not administered:	A 038		

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A 038	Continued From Page 4	A 038		

1.) June 2019. The following medications and dates were left blank on the MAR:

a.) Fluoxetine capsule 20 mg to be taken once daily: Missing documentation on 6/20, 6/26, and 6/29.

b.) Levetiraceta tablet 250 mg to be taken twice daily: Missing documentation on 6/20 (one dose), 6/26 (one dose), and 6/29 (one dose).

c.) Polyethylene glycol powder 8.5 gms in 4-8 ounces of water daily: Missing documentation on 6/20, 6/26, and 6/29.

d.) Quetiapine tablet 50 mg, 1.5 tablets daily: Missing documentation on 6/20.

e.) Ranitidine tablet 150 mg, 1/2 tablet taken twice daily: Missing documentation on 6/20 (one dose).

f.) Senna 8.6 mg tablet to be taken daily: Missing documentation on 6/14, 6/20, 6/26, and 6/29.

2.) July 2019. The following medications and dates were left blank on the MAR:

a.) Fluoxetine capsule 20 mg to be taken once daily: Missing documentation on 7/7, 7/9, 7/10, 7/12, 7/15, 7/17, 7/18, and 7/27

b.) Levetiraceta tablet 250 mg to be taken twice daily: Missing documentation on 7/7 (one dose), 7/9 (one dose), 7/10 (one dose), 7/12 (one dose), 7/15 (one dose), 7/17 (one dose), 7/18 (one dose), and 7/27 (one dose).

c.) Polyethylene glycol powder 8.5 gms in 4-8 ounces of water daily: Missing documentation on 7/5, 7/7, and 7/9, 7/10, 7/12, 7/15, 7/17, 7/18, and 7/27.

d.) Ranitidine tablet 150 mg, 1/2 tablet taken twice daily: Missing documentation on 7/5 (one dose), 7/7 (one dose), 7/9 (one dose), 7/10 (one dose), 7/12 (one dose), 7/15 (one dose), 7/17 (one dose), 7/18 (one dose), and 7/27 (one dose).

e.) Senna 8.6 mg tablet to be taken daily:

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A 038	Continued From Page 5 Missing documentation on 7/5, 7/7, 7/9, 7/10, 7/12, 7/15, 7/17, 7/18, and 7/27. A review of Program policies on 9/16/19 revealed the policy titled: Resident Self-Administration of Medication. The policy revealed the following: "When medications are administered traditionally by Grand Living: Grand Living shall maintain a list of each resident's medications and document the medications administered." On 9/19/19 at 11:45 AM, the Director and the Director of Nursing confirmed the above gaps in the medication administration record for Tenant #1.	A 038		
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 ensure the medications for 1 out of 3 tenants reviewed were administered as ordered by the physician (Tenant #1). Findings include: On 9/16/19, a review of tenant records revealed the following: Tenant #1 was admitted to the Program on	A 147		

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A 147	Continued From Page 6 8/20/18 with a diagnosis of Alzheimer's disease, hyperlipidemia, major depressive disorder, hypertension, anxiety, and insomnia. Tenant #1 had an order dated 6/4/19, for methadone 5 mg. The was to be split in half, resulting in 2.5 mg given each night prior to bed. A review of hospice notes for Resident #1 on 9/17/19 and an interview with Tenant #1's hospice nurse on 9/17/19 at 1:11 p.m., revealed the following information: 1). On 6/24/19, the Assistant Director of Nursing (ADON) contacted hospice to report only having one dose of methadone left that would be administered that night. 2.) Hospice informed the ADON that the methadone was supplied on 6/16/19 and seven 5 mg tablets were delivered for Tenant #1 from an emergency pharmacy due to it being last minute on a weekend. Seven tablets would have covered 14 days of medication. The ADON informed the hospice nurse that because staff were used to the tablets being delivered already cut in half, staff administered the tablets in whole form on several days which would have resulted in Tenant #1 receiving a double dosage of the methadone medication and would run out early. A comparison of the hospice notes and medication timeline on 9/17/19, revealed the resident would have received a double dosage of the methadone medication for 5 days out of the 14 days the resident should have been supplied with the medication. The doctor was notified on 6/24/19. Tenant #1 showed minor signs of sleepiness due to the medication error. A review of Tenant #1's medication administration record (MAR) revealed on 7/11/19, 7/12/19, 7/13/19 and 7/14/19, Tenant #1's order for 2.5 mg	A 147		

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A 147	Continued From Page 7 of methadone at bedtime had dropped off of the documentation record. Nurse's notes completed on 7/17/19 by the Director of Nursing (DON) revealed a notation that Tenant #1 had not received her methadone dosage on 7/12/19 and 7/13/19 due to the medication being absent from the MAR. On 9/18/19 at 9:31 p.m. after review of Tenant #'s MAR, the Director of Nursing stated the methadone order for Tenant #1 was actually absent from the MAR on 7/11/19, 7/12/19, 7/13/19 and 7/14/19 resulting in 4 days without the medication. No side effects were noted. A review of Program policies on 9/16/19 revealed the policy titled: Resident Self-Administration of Medication. The policy revealed the following: "When medications are administered traditionally by Grand Living: Medications shall be administered as prescribed by the resident's physician, ARNP or PA." On 9/19/19 at 11:45 a.m., the Director and the DON confirmed Tenant # 1's medications were not administered as prescribed in both incidents.	A 147		

OK 11/20/19

Plan of Correction
Grand Living at Bridgewater

A008 -Program Policies and Procedures

Regulatory Insufficiency: The Program failed to complete an incident report for 1 of 3 residents reviewed on two separate medication errors.

Plan of Correction:
The insufficiencies will be corrected as follows:

- With any tenant medication error, a report will be completed per policy (Attachment A).

The following measures will be taken to ensure the problem does not recur:

- Review and re-education of *Incident Reporting Policy and Procedure* related to medication errors provided to healthcare staff, including step-by-step instructions of completing the report within EMR (Attachment B) will be provided to all healthcare staff at the November 14, 2019 and November 15, 2019 scheduled in-service.

The program will monitor performance to ensure compliance as follows:

- Program nurse or designee will monitor completion of incident reports for all reported tenant medication errors.

Date insufficiencies corrected by: November 28, 2019.

A038 -Medications

Regulatory Insufficiency: The program failed to ensure all medications administered were documented on the Medication Administration Record (MAR).

Plan of Correction:
The insufficiencies will be corrected as follows:

- All tenants receiving medication administration by the program will be documented per policy on the MAR (Attachment C).

The following measures will be taken to ensure the problem does not recur:

- Review and re-education of Medication Management Agreement (Attachment D) will be provided to all healthcare staff at the November 14, 2019 and November 15, 2019 scheduled in-service.

The program will monitor performance to ensure compliance as follows:

- Program nurse or designee will monitor the EMAR dashboard periodically and no less than weekly for three months to review and ensure proper documentation of any missed medications.

Date insufficiencies corrected by: November 28, 2019

A147-Medications

Regulatory Insufficiency: The Program failed to ensure the medications for 1 out of 3 tenants reviewed were administered as ordered by the physician.

Plan of Correction:

The insufficiencies will be corrected as follows:

- All tenants receiving medication administration by the program will be administered per physician's order.
- Sufficient quantity of medication for Tenant #1 verified on weekly basis prior to end-of-business week by Program nurse and re-ordered as needed.

The following measures will be taken to ensure the problem does not recur:

- Review and re-education provided to healthcare staff on Resident Self-Administration of Medication Policy and Procedure (Attachment C) and Medication Management Agreement (Attachment D) at the November 14, 2019 and November 15, 2019 scheduled in-service.
- Program nurse or designee and outside providers will collaborate care to ensure the accuracy of all medications prescribed by physician on a routine basis.

The program will monitor performance to ensure compliance as follows:

- Program nurse or designee will review medication bubble packs and/or bottles on a monthly basis to verify accurate dose of medication has been filled by pharmacy.

Date insufficiencies corrected by: November 28, 2019.