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 |
|---|---|---|---|
| | S0387 | A. BUILDING: _____ B. WING _____ | C 08/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNINGSTAR AT JORDAN CREEK AL | 525 S 60TH STREET WEST DES MOINES, IA 50266 |

| (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<br><br>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.<br><br>Number of tenants without cognitive impairment: 44<br>Number of tenants with cognitive impairment: 4<br>Total census:48<br><br>The following regulatory insufficiency was cited during the investigation of Complaint #122948-C. | A 000 | | |
| 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 staff failed to follow established medication policies regarding 1 of 1 tenants reviewed with diabetes (Tenant #1). Findings include:<br><br>On 8/26/24 at 12:40 p.m. the Wellness Director (WD) reported a recent medication error had occurred. On 8/21/24 Staff D (a former medication manager) was thought to have administered Tenant #1's insulin in error when he already had a low blood sugar reading of 51. EMS (emergency medical services) was called and Tenant #1 was transported to the hospital for low blood sugar readings with information showing his insulin had been administered during | A 150 | -Physician orders in place regarding hold parameters for all glucose monitored insulins.<br><br>-Staff will dial insulin pen and show resident prior to assisting with administration.<br><br>-We have retrained all medication managers on policy/procedure, medication errors, blood glucose monitoring, and insulin administration if applicable. | |

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

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| A 150 | Continued From page 1 | A 150 | | |

the 12:00 p.m. medication pass.

On 8/21/24 when the WD was gathering information to report the error to the tenant's primary care physician, she realized Staff D had later edited Tenant #1's eMAR (electronic Medication Administration Record). She changed her administration of 20 units of Novolog to Tenant #1 during the noon medication pass on 8/21/24 to "not passed" indicating she did not administer any insulin. The WD reported she thought Staff D had made this change after realizing what she had done when Tenant #1 was sent to the hospital for low blood sugar.

On 8/27/24 at 12:44 p.m. record review revealed Staff D was hired on 9/19/2022 and had completed her Medication Managers Course on March 10, 2023. Review of Staff D's job description revealed she worked in a supervisory role as an Assisted Living Coordinator.

On 8/27/24 at 12:55 p.m. review of Tenant #1's service plan revealed he had delegated his blood glucose monitoring and his insulin administration to the Program. Tenant #1's physician's orders included Novolog 20 units sub-q three times daily at meals, and 50 units of Lantus insulin every 12 hours.

Review of the Blood Sugar monitoring record for Tenant #1 revealed insulin was not to be given if blood sugar was under 60. His blood sugar reading taken by Staff D at 10:54 am on 8/21/24 was 51.

When interviewed on 8/27/24 at 3:43 p.m. Staff D reported she noted on Tenant #1's eMAR she had administered insulin when she had not. Staff D adamantly denied giving Tenant #1 his second

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| A 150 | Continued From page 2 | A 150 | | |

dose of insulin during the 12:00 p.m. medication pass on 8/21/24 when the tenant's blood sugar tested low. Staff D reported she gave Tenant #1 his first dose of insulin earlier that morning that consisted of 20 units of Novolog and 50 units of Lantus Solostar. For the second medication pass she took his epipen with the Novolog insulin and the blood testing kit to first test his blood sugar and then give him his insulin if needed. She stated Tenant #1's blood sugar was low at 51. She did not draw up and administer his insulin to him at that time but noted on the eMAR she had given Tenant #1 his 20 units of Novolog Insulin. She told both Staff E and Staff F to get him a tray of food with orange juice and take it to his room in hopes of bringing his blood sugar up. She reported she would give him his insulin after she retested him. Since she would still be in the window to give the insulin (one hour before and one hour after the scheduled time) she thought it would be ok to not edit the eMAR. However, 911 was called at that time and preparation to transfer the resident was underway. While on the phone with 911, the nurse asked her what the tenant's blood sugar was and she told her 51. She did not tell the nurse who called 911 at 12:21 p.m. that Tenant's #1's eMAR sheet was not accurate. The eMAR showed Tenant #1 was given his 20 units of Novolog before being sent to the hospital with low blood sugar.

On 8/27/24 at 2:25 p.m. review of the Medication Errors policy revealed staff will be trained to promptly report medication errors/incidents. When a medication error is discovered the team member assisting the affected resident with medications and treatments will notify the Wellness Director or designee and the Executive Director.

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| A 150 | Continued From page 3<br><br>On 8/28/24 at 2:18 p.m. review of the Medication Administration policy staff were to sign the eMAR to correspond with the medication given (administered).<br><br>On 8/29/24 at 4:40 p.m. the Administrator confirmed these findings. | A 150 | | |