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
	S0388	A. BUILDING: _____ B. WING _____	C 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDHAVEN ASSISTED LIVING CENTER	5500 SOUTH MAIN STREET CEDAR FALLS, IA 50613

(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: 75 Number of tenants with cognitive impairment: 6 Total census: 81 The following regulatory insufficiency was cited related to the investigation of Complaint #119483-C:	A 000	All Resident Assistants/Medication Managers have been re-educated on the 6 rights of Medication Administration and proper documentation. This includes documenting that medications have been given, documenting the reason a resident has refused medication and the importance of giving medication at the prescribed time per Physician orders. The R.N. Clinical Directors will review Medication administration records no less that quarterly to ensure compliance. Completion date 1/ 24/2025	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures related to medication errors. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings include: 1. On 11/8/24 review of a staff member's Employee Disciplinary Report dated 2/15/24 revealed on 2/12/24 a tenant (Tenant C1) reported she did not receive all of her evening medications the day prior. Two medications were left in the bubblepack and the other medications were popped out of their package. On 2/11/24	A 150		

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A 150	Continued From page 1	A 150		

two tenants' medications that were required to be counted had not been signed out but had been given.

A handwritten note attached to the Employee Disciplinary Report indicated on 2/12/24 Tenant C1 reported on the evening of 2/11/24 she received four pills and she usually received more than that. It also noted Tenant C2 had Tramadol that was given but was not signed out and Tenant #2 had clonazepam at bedtime that was given but was not signed out.

2. Review of Tenant #2's file on 11/6/24 revealed she received staff assistance with medications. Her February 2024 medication administration records (MARs) reflected she had an order for clonazepam tablet 0.5 milligram (mg) at bedtime. Per the report above Tenant #2 had clonazepam at bedtime that was not signed out on 2/11/24.

3. Review of Tenant C1's file on 11/6/24 revealed she received staff assistance with medications. Her February 2024 MAR reflected Tenant C1 had the following medications ordered at 8:00 p.m.
- Atenolol 25 mg tablet, one tablet daily at bedtime. It was documented as administered on 2/11/24.
- Omeprazole 20 mg capsule, one capsule daily at bedtime. It was documented as administered on 2/11/24.
- Quetiapine 25 mg, one and one-half tablets daily at bedtime. It was documented as administered on 2/11/24.
- Sertraline 50 mg, one tablet daily at bedtime. It was documented as administered on 2/11/24.
- Acetaminophen 500 mg, two tablets twice daily. It was initialed by staff and circled with no explanation provided.

As a result, it appeared the tenant received 4½

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A 150	Continued From page 2 pills instead of the 6½ that were ordered. 4. Review of Tenant C2's file on 11/6/24 revealed she received staff assistance with medications. The February 2024 MARs reflected she had an order for Tramadol HCL 50 mg tablet in the a.m. or at bedtime as needed. It was documented as administered on 2/10/24 and 2/11/24 at 5:00 p.m. (despite being ordered at a.m. or bedtime). The Controlled Drug Receipt Record/Disposition Form did not reflect the two doses of Tramadol signed out on 2/10/24 or 2/11/24. Per the report noted above the Tramadol was given but not signed out on 2/11/24. 5. The Program's policy and procedure related to medication errors indicated all accidents or unusual occurrences would be reported as incidents. A report would be completed in detail and the report would be kept on file for three years. Further record review revealed there were no medication error reports completed related to the medication errors noted on 2/11/24 related to Tenant #2, Tenant C1 or Tenant C2's medications. When interviewed on 11/6/24 at 3:37 p.m. the Senior Director of Clinical Services confirmed there were no other medication errors known related to the tenants above.	A 150		