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
	S0411	A. BUILDING: _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF CEDAR RAPIDS	5710 DEAN ROAD SW CEDAR RAPIDS, IA 52404

(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 disorder: 27 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 27 The following regulatory insufficiency was cited during the investigation of Complaint #88243-C and the initial certification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	See attached POC 3/6/20	
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 as ordered by tenants' physicians. This pertained to 2 of 4 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Record review on 3-3-20 revealed an incident report, dated 11-28-19, documented on 11-26-19	A 147		

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A 147	Continued From page 1 a 12 microgram (mcg) patch (Fentanyl) was placed by staff on Tenant #1 and it should have been a 25 mcg patch. Tenant #1's physician was made aware and a 25 mcg patch was applied. Continued record review on 3-4-20 revealed Tenant #1's file included a service plan dated 11-14-19. The service plan indicated Tenant #1 had a pain patch and staff applied the patch. Staff administered Tenant #1's medications and the medications were stored in a locked box in the apartment. The service plan also reflected Tenant #1 had chronic pain, which she had for years. Further record review revealed a Medication Review Report indicated Tenant #1 had an order dated 10-14-19 for a Fentanyl patch 12 mcg/hr, apply one patch, transdermally, every 72 hours for pain and to remove per the schedule. An order was received dated 10-24-19 that reflected the Fentanyl patch was increased to 25 mcg/hr every 72 hours. The order was noted on 10-24-19 at 2:00 p.m. Continued record review revealed the November 2019 medication administration records (MARs) reflected staff documented the Fentanyl patch 25 mcg/hr, apply one patch, transdermally, every 72 hours was documented as completed on 11-26-19. The Controlled Substance Shift Count and Usage Record (12 mcg/hr) reflected the count of one 12 mcg patch from 10-23-19 at 2:00 p.m. through 11-26-19. It was noted on the back of the record on 11-27-19 that one patch was taken on 11-26-19 and no patches remained. The Controlled Substance Shift Count and Usage Record (25 mcg/hr) reflected a patch was applied	A 147		

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A 147	Continued From page 2 on 11-26-19 at 2:30 p.m. On 11-27-19 it was noted a patch was not administered on 11-26-19 and 10 patches remained. When interviewed on 3-5-20 at 9:46 a.m. the Nurse confirmed Tenant #1 received a 12mcg Fentanyl patch, when she should have received a 25 mcg patch. The Nurse explained Tenant #1's Fentanyl patch increased from 12 mcg to 25 mcg and there was one patch left when the change occurred. The patch was not wasted right away and staff utilized the 12mcg Fentanyl patch with Tenant #1. The following day the narcotic count was off (it was completed once daily at 2:00 p.m.) Staff notified the Nurse of the count being off. Tenant #1's physician was notified and directed to remove the 12 mcg patch and apply the 25 mcg. The Nurse confirmed the remaining 12 mcg patch should have been destroyed right away. 2. Record review on 3-3-20 revealed an incident report dated 11-25-19 documented on 11-22-19 Tenant #2 received Fentanyl 25 mcg/hr. On 11-23-19 it was reported Tenant #2 was not feeling well and he was taken to the hospital via ambulance. It was determined the pharmacy sent a prescription with the wrong name (Tenant #2). Staff administered one patch without verification of the original prescription. Continued record review of Tenant #2's file revealed Tenant #2's service plan dated 11-6-19 reflected he self-administered medications. The service plan dated 11-22-19 reflected staff administered Tenant #2's Fentanyl patch and it was changed every three days per the MAR/orders. The patch was stored in the narcotic box. The service plan was updated on 11-25-19 and removed the Fentanyl patch and	A 147		

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A 147	Continued From page 3 assistance with the patch. Review of progress notes indicated the following: a. On 11-22-19 an order was received for Fentanyl 25 mcg, change every three days. Tenant #2 was independent with his medications; however, requested staff assisted. b. On 11-25-19 Tenant #2 received Fentanyl 25 mcg/hr, one patch on 11-22-19. On 11-23-19 it was reported Tenant #2 was not feeling well and was sent to the hospital via ambulance. The pharmacy had sent a prescription with the wrong name which was Tenant #2. Staff administered one dose. Tenant #2 returned to the Program with no new orders. Tenant #2 had returned back to his baseline and Tenant #2's family was notified. A New Prescription Form dated 11-11-19 indicated an order received for Fentanyl patch 25 mcg/hr, transdermal patch, every 72 hours (quantity 5 patches) one patch onto the skin every third day. The person listed on the order was not Tenant #2 and the physician listed was not Tenant #2's primary care provider. Continued record review revealed Tenant #3's November 2019 MAR reflected Fentanyl patch 25 mcg/hr, one patch applied transdermally, every 72 hours for pain. The order was started on 11-22-19 and discontinued on 11-25-19. The MARs reflected a patch was administered on 11-22-19 at 2:11 p.m. A Controlled Substance Shift Count and Usage Record reflected Fentanyl 25 mcg/hr patches for Tenant #2. The first entry on 11-11-19 at 9:20 p.m. reflected five patches. From 11-11-19 to	A 147		

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A 147	Continued From page 4 11-25-19 staff counted the patches. On 11-22-19 at 2:00 p.m. one patch was reflected as applied with the amount remaining as four patches. It indicated four patches were destroyed. The Program's policy and procedure for Medication Management revealed a physician's order must be received when medication administration was delegated to the Program. Medications would be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. When interviewed on 3-5-20 at 9:46 a.m. the Nurse revealed Tenant #2 was independent with medications at that time. Pharmacy delivered patches and she was notified there was a box of patches in the memory care unit. The patches had been there for five days and the patches had Tenant #2's name. The Nurse spoke with Tenant #2 and he said he had talked with his family regarding possibly needing it. Tenant #2 said he might need help and the Nurse applied the patch (one time). Tenant #2 then requested that staff assisted with the application of the patch. The Nurse contacted the pharmacy and an order was faxed from the pharmacy. The order was put on the MAR. The Nurse received a text message on Saturday or Sunday from the Assisted Living (AL) Director that indicated Tenant #2 was taken to the emergency room due to the Fentanyl patch. Tenant #2 was not admitted when he went to the hospital. The patch was removed and he returned the same day. On Monday the error was noted when the AL Director requested an order for the Fentanyl patch. The order had a name that was not Tenant #2. Pharmacy was contacted and an order was sent and it had a name that was not Tenant #2. It was for a person that did not reside on the campus. The AL Director called	A 147		

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A 147	Continued From page 5 Tenant #2's family. Regarding corrective action, the Nurse had re-education completed and the issue was discussed with the pharmacy. When interviewed on 3-4-20 at 10:02 a.m. the AL Director revealed Tenant #2 had a procedure done and had some pain for a few days. Pharmacy sent a Fentanyl patch and the Nurse delivered it and asked if he heeded help with it. The Nurse put on the patch. It was ordered for a person that did not reside on the campus.	A 147		

5/1/20

April 29, 2020

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

Dear Ms. Campbell:

On behalf of The Gardens of Cedar Rapids, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Investigation Report dated April 20, 2020. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the alleged insufficiencies or conclusions set forth in the report. The plan of correction is prepared and/or executed solely because it is required by the provision of the law.

Medication Management

1. Elements detailing how the program will correct each regulatory insufficiency.
    - For tenant 2 the patch was removed and the order was dc'd. The excess patches were destroyed. For tenant 1 the higher, correct dosage was provided the next day.
2. What measure will be taken to ensure the problem does not recur.
    - Nurse education on noting orders and follow through with med disposal was done 12/4/2019 and reviewed 3/6/2020.
3. How the program plans to monitor performance to ensure compliance.
    - We will review use of 1 patch in house monthly for three months.
4. The date by which the regulatory insufficiency will be corrected.
    - This insufficiency was correct 3/6/2020

If you have any question regarding this plan of correction, please feel free to contact me at 319-632-1350. Thank you.

Sincerely,

Jenna Gardner
Executive Director