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
	S0424	A. BUILDING: _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPER CREEK	609 HWY 150 NORTH WEST UNION, IA 52175

(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: 12 Number of tenants with cognitive impairment: 2 Total census: 14 The following regulatory insufficiency was cited during the investigation of Complaint # 117168-C.	A 000		
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 the internal policy regarding medication errors for 1 of 3 tenants reviewed (Tenant # 3) Findings include: 1. Record review on 12/19/23 revealed Tenant # 3 was admitted to the Program 11/1/23. On 12/19/23 at 1:19 pm, Tenant # 3 stated there were several times she had not received her medications at all or the correct amount of medications. Tenant # 3 stated her medications were incorrect more than twice in November. She reported the problem was fixed and she hadn't noted further concerns as of December. 2. Record review on 12/18/23 revealed the	A 150		

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A 150	Continued From page 1 Program's medication error reports for October, November, and December of 2023. Tenant # 3 had medication error reports on file. 3. When interviewed on 12/19/23 at 2:30 pm, the Healthcare Coordinator confirmed there were more than two medication errors that occurred to Tenant # 3. The Healthcare Coordinator stated she learned of a medication error on 11/20/23 that occurred to Tenant # 3. The Healthcare Coordinator could not determine how many times the error occurred. The error was that Staff F administered the wrong dosage of one medication for Tenant # 3. The Healthcare Coordinator stated Tenant # 3 was to receive 1.5 tablets of Metoprolol twice a day. The Healthcare Coordinator learned Staff F had only administered 1 tablet during her medication administration. The Healthcare Coordinator stated after the error was discovered she added a more obvious label to the top of the bottle that indicated the dosage and Staff F as well as other medication managers were retrained on the proper dosage. The Healthcare Coordinator confirmed she hadn't completed a medication error form for the incident. 4. Further record review on 12/19/23, revealed Tenant # 3's medication order, dated 11/2/23, directed Metoprolol Tartrate 50 mg tablet, 1.5 tablets to be given twice a day by mouth. 5. On 12/20/23, a review of the Program's "Med Error" policy was reviewed. The Med Error policy indicated the staff involved with the medication error would complete a medication error form if a medication error occurred or was discovered. 6. On 12/20/23 at 12:30 pm, the Community Director, the Registered Nurse (RN), and the	A 150		

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A 150	Continued From page 2 Healthcare Coordinator confirmed the Program's policy was not followed for the error involving Tenant #3.	A 150		