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
	S0444	A. BUILDING: _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE AL	1140 KENNEDY PARKWAY CORALVILLE, IA 52241

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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: 62 Number of tenants with cognitive impairment: 1 Total census: 63 The following regulatory insufficiencies were cited during the recertification visit to determine compliance with rules for assisted living programs and investigation #119257-C.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure 1 of 1 tenants reviewed who was hospitalized for a drug overdose received adequate care, treatment and services (Tenant #1). Findings follow: On 3/4/24 review of an incident report dated 2/23/24 at 7:15 PM identified Staff A went to Tenant #1's apartment to pass medication. Tenant #1 was laying in bed and Staff A called out	A 160	The Plan of Correction is attached	

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

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to her. Staff A shook Tenant #1 several times but received no response. Tenant #1 was breathing but not waking up. Staff A called the nurse, explained the situation and was directed to call 911. Tenant #1 went to the emergency room.

The DON (Director of Nursing) documented in the progress notes she received a call from the hospital social worker on 2/29/24 letting them know they were preparing to discharge Tenant #1. The social worker wanted the DON to know Tenant #1 had overdosed unintentionally on Tylenol PM.

The program received an order from Tenant #1's primary care provider (PCP) on 11/7/23 for Tenant #1 to use Narcan as needed due to opiate usage. The Centers for Disease Control listed Narcan as a life-saving medication which could reverse an overdose from opioids, including prescription opioid medications. Tenant #1 was prescribed an opioid medication, Morphine. The directions on the use of Narcan included to use 1 spray into one nostril once as needed. Repeat with a second device into the other nostril after 2-3 minutes if no or minimal response.

On 3/6/24 at 3:30 PM Staff A recalled she went to give Tenant #1 her bedtime medication on 2/23/24. Staff A always called out to let Tenant #1 know when she entered the apartment, but that night Tenant #1 didn't answer. When Staff A spoke to Tenant #1 she did not receive a response so she shook her again. Tenant #1 was laying on her bed in a position which did not appear comfortable. Staff A called the DON who instructed her to call 911. After the Emergency Technician's (EMTs) arrived, Staff B entered the apartment and told them Tenant #1 had Narcan. Staff B said give her Narcan and the EMTs

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administered this twice. Tenant #1 woke up after the second dose. Staff A reported she knew Tenant #1 had Narcan at one time because she was delegated on how to use the medication by the previous DON. The previous DON told them how to administer Narcan if Tenant #1 ever needed it. When Tenant #1 was initially administered Narcan, it was stored in the medication cart with the narcotics. When the current DON was hired, the Narcan was no longer stored in the medication cart, so she thought Tenant #1 did not use Narcan any longer.

On 4/3/24 at 9:56 AM Staff B reported she was working on the memory care unit when she heard the ambulance sirens. Usually the EMTs turn the sirens off when they get close to the building but they did not do so that day so she knew something was really wrong. Staff B went to the front desk and Staff A informed her Tenant #1 was non-responsive. Staff B informed Staff A Tenant #1 had Narcan. When Staff B was first trained on how to use Narcan she recalled the medication was stored in an orange box. She thought the previous DON showed her how to administer Narcan to a tenant. Staff B was a medication aide, so she knew Tenant #1 was prescribed Narcan. When she got to Tenant #1's apartment, she told the paramedics the tenant needed Narcan. She and Staff A looked through the medication box but couldn't find the Narcan right away because she was looking for an orange box and now Tenant #1's box of Narcan was white. The paramedics said they had their own supply and administered it. Staff B was not delegated on the use of Narcan by the current DON.

On 3/5/24 at 10:04 AM, the DON reported she had contacted the PCP about the order for

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Narcan as no other tenants at the program were prescribed Narcan. According to the DON, the PCP prescribed the Narcan as Tenant #1 received Morphine. The DON reported she talked with staff about Tenant #1 taking Narcan but had no documentation about this. The DON considered the use of Narcan to be similar to other nasal sprays and staff were delegated about the use of nasal sprays. The DON instructed newly hired staff (since 11/7/23) Narcan was a medication a tenant had and how it should be used.

On 4/3/24 at 9:43 AM, the DON reported on 2/23/24 she could did not recall Tenant #1 used Narcan which was why she did not instruct Staff A to administer it. The DON told staff to administer a sternal rub. If one of the staff members told her Tenant #1 had Narcan, she would have told them to administer it. The DON confirmed it would have been important for staff to know Tenant #1 had Narcan available. On 2/23/24, staff had not been trained by her on how/when to use Narcan.

A review of progress revealed the DON spoke with Tenant #1's sister following the incident on 2/23/24 about medication bottles found in Tenant #1's apartment which were not prescribed. The DON noted there were a large number of medications, too many to count. There were bottles of Tylenol, Excedrin, Excedrin Migraine, Nyquil and a lot of medications with no markings on them in cups and bottles. The guardian was going to remove the pills on that date. As of 3/4/24, staff had not returned to the apartment to determine if it was a safe place to which the tenant could return.

On 3/4/24 at 3:30 PM, Staff A reported she had not ever seen pill bottles in Tenant #1's

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apartment. However, the tenant received many packages from Amazon. She could hear the pills rattle when she delivered them to the apartment. Tenant #1 had a private caregiver. The first caregiver Tenant #1 employed quit because she was reportedly afraid she would enter the apartment and find Tenant #1 dead from a medication overdose.

On 3/4/24 at 2:05 PM, Staff C reported she had not seen bottles of medication in Tenant #1's apartment, but in the past Tenant #1 ordered a lot of medication. The Executive Director and DON were aware of this.

On 3/4/24 at 2:20 PM the DON stated Tenant #1 had a habit of ordering medication off Amazon. After Tenant #1 went to the hospital, they found over-the-counter drugs in an open drawer in the apartment. The DON called Tenant #1's sister and asked for permission to go in the apartment and look for medication. The DON and another staff member opened drawers and there were 2 drawers full of Tylenol, Tylenol PM, Excedrin, Pepto-Bismol, mouth wash and Afrin nose spray. They then opened the secretary which was also packed full of medication. There were med cups in the secretary with some sort of medication in them. Tenant #1's sister agreed to remove the medication for her sister's safety. The sister took out 2 garbage bags of medication. The hospital social worker told the DON Tenant #1 unintentionally overdosed on Tylenol PM.

A review of Tenant #1's hospital discharge summary noted her principal problem at the time of admission was drug overdose of undetermined intent, initial encounter. Over the course of Tenant #1's stay in the hospital, she experienced urinary retention and needed intermittent catheterization.

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A 160	Continued From page 5 Her doctor believed this was due to Benadryl use which was discontinued. Tenant #1 returned to the program on 3/5/24. On 3/5/24 at 9:30 AM the DON confirmed she was not aware of the number of medications or what type of medication Tenant #1 was taking.	A 160		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation and interview, staff failed to administer medication in a sanitary manner to 2 of 3 tenants observed during a medication pass (Tenant #2 and Tenant #3). Findings follow: Staff D was observed administering medication to three tenants on 3/5/24 between 8:25 AM and 8:50 AM. While Staff D was in the process of placing Tenant #2's pills in a medication cup, she knocked the cup onto the floor. Staff D picked the pills up from the ground, put them back in the medication cup and administered them to Tenant #2. Staff D went to Tenant #3's apartment next. She dropped a bottle of Venlafaxine 150mg. belonging to Tenant #3, spilling a handful of pills on the floor. Staff D picked up the pills from the ground,	A 361		

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A 361	Continued From page 6 placed them back in the bottle and continued the medication administration process. On 3/5/24 at 9:30 AM, the Director of Nursing confirmed she trained staff they should not administer pills to tenants if they fell on the ground.	A 361		

STIRLINGSHIRE
DIAL SENIOR LIVING

Plan of Correction for Stirlingshire of Coralville AL
In Response to
Recertification & Complaint Investigation
Dated 4/23/2024
Complaint #119257-C / Civil Penalty Citation #10313

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: Tenant Rights 481-67.3(2)

67.3(2) All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Narcan nasal spray ordered and placed in med cart.
    b. All medications removed from resident apartment and placed in med cart.
    c. Negotiated risk put into place on 3/6/2024.
2. **What measures will be taken to ensure the problem does not recur.**
    a. DON and/or designee completed education with all nursing staff regarding the use of Narcan Nasal Spray including indications for use, how to use, and storage location
    b. DON and/or designee to inform medication aides when any resident receives a new order for Narcan Nasal Spray
3. **How the program plans to monitor performance to ensure compliance.**
    a. DON and/or designee to ensure that Narcan Nasal Spray is delivered and placed in med cart when new order received by provider.
    b. Regional Nurse and/or designee will periodically audit documentation and medication carts for completion during visits to community.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. 3/31/2024

Regulatory Insufficiency: Staffing 481-67.9(4)f

481-67.9(4)f Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: Services shall be provided to tenants in accordance with the training provided.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
    a. DON and/or designee to provide education to all medication aides regarding destruction of medications and the process for a dropped medication.
2. **What measures will be taken to ensure the problem does not recur.**
    a. DON and/or designee to randomly review medication destruction and process for dropped medications
    b. DON and/or designee to review process for medication destruction and dropped medications with all 30 day delegations, annually, and as needed.
3. **How the Program plans to monitor performance to ensure compliance.**
    a. DON and/or designee to randomly shadow med passes to ensure compliance.
    b. Regional DON to perform random audits of documentation and 30 day delegations.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. 4/30/2024

Sincerely,

Amy Kubik-Hasley, Executive Director

✓ 6/27/24