STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa Jewish Senior Life Center	900 Polk Boulevard Des Moines, IA 50312

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40905 Based on observation, record review and staff interview, the facility failed to meet professional standards by not observing a resident take their medications for 1of 8 residents (Resident #18) reviewed. The facility reported a census of 51 residents. Findings include: A Minimum Data Set (MDS) for Resident #18, dated 3/12/24, included diagnoses of heart failure, anxiety, and depression. The MDS documented the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. Observation on 4/15/24 at 12:05 PM, resident in room and holding medication cup with several pills in the cup. Resident stated they always leave them for me, they know I will take them as they are good for me. Review of the resident's Medication Administration Record dated 4/1/24 - 4/30/24, documented the following medications ordered and administered at noon: a. ascorbic acid (supplement) b. aspirin c. buspirone (anti-anxiety) d. cholecalciferol (supplement) e. ditiazem (high blood pressure) f. duloxetine (anti-depressant) g. ferrous gluconate (iron supplement) h. furosemide (diuretic for fluid retention) i. L-Lysine (canker sore) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. metoprolol (high blood pressure) k. Tylenol l. Zyrtec (allergies) Interview on 4/17/24 at 11:36 AM, Staff B, Licensed Practical Nurse (LPN) stated she always stays with residents until they take their medication and does not leave medications with any residents. Interview on 4/17/24 at 12:08 PM, Staff C, LPN stated she always stays with residents until they take and swallow their medication, the protocol is to stay with the resident and no residents are able to self-administer their medications. Facility policy titled Administration of Medication, dated 6/28/2023, directed staff to remain with the resident to ensure that the medication is swallowed. Interview on 4/17/24 at 2:47 PM, the Director of Nursing stated she expects staff to remain with the residents until the medication is swallowed and recently provided education to the staff regarding this.

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NAME OF PROVIDER OR SUPPLIER: Iowa Jewish Senior Life Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 Polk Boulevard, Des Moines, IA 50312	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, family and staff interview and policy review, the facility failed to prevent a significant medication error for 1 of 11 residents reviewed (Resident #155). The facility reported a census of 51 residents. Findings Include: The Baseline Care Plan of Resident #155 reflected a date of 4/10/24. The Care Plan documented the resident unable to easily communicate with staff, and to be vision and hearing impaired. The Admit/Readmit Summary, dated 4/10/24 at 7:35 pm, documented the resident admitted to the facility on [DATE], was oriented to self and to place, not to time. The Summary also documented the resident to have moderately impaired vision and moderate difficulty hearing. The Health Status Note, dated 4/13/24 at 7:20 am, documented the resident to be very confused and anxious and not able to follow direction. The Health Status Note, dated 4/13/24 at 11:22 am, documented Resident #155 was in a wheelchair in the dining room when approached by a medication aide and called by a name other than her own. Per the note, the resident responded to the other name and then given 650 mg of Tylenol and 0.25 milliliters of morphine intended for the other resident. After administering the medication, per the note, the medication aide then went to Resident #155's room for medication pass and then realized her error and notified the nurse on duty. The physician, family member of the resident, and nurse manager were informed of the error and the resident monitored. The Order Note, dated 4/13/24 at 5:56 pm, documented the resident's daughter chose to send the resident to the emergency room for evaluation. On 4/15/24 at 4:26 pm, a family member of Resident #155 stated the resident had blood work done upon arrival to the facility, prior to the medication error, which showed high potassium and high creatinine levels. She stated the medical director had made some medication changes due to the abnormal laboratory values. She stated when the resident arrived at the hospital, she had a CT scan (computed tomography, a test to obtain internal images of the body) which showed no concerns and she tested negative for having a urinary tract infection. She stated the hospital did not appear concerned the mental status change was related to the morphine error. The lab work collected on 4/13/24 at 5:45 pm reflected a potassium level of 5.9 (normal values 3.5-5.1). and a Creatinine of 1.6 (normal values 0.6-1.1). The History and Physical from the hospital also noted the resident was abruptly taken off of tramadol after 4 years of chronic use and documented may need to add back tramadol and slowly taper off if necessary to avoid acute detox. Hospital notes reflected mental status change likely related to hyperkalemia (high potassium) which was present prior to morphine administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 12:56 pm, Staff D, Certified Medication Aide stated she had been employed at the facility since 2018. She stated when she arrived to work on 4/13/24, she was scheduled to work the floor in the memory care unit, which is not where resident #155 resided. She stated the nurse in the part of the facility where Resident #155 resided had been busy and the nurse needed assistance to complete the morning medications. She voiced once she got all of her residents up and dressed on the memory care unit, she was asked to go help in the other portion of the building. She said she always works in the memory care unit and had never met either of the residents who she got mixed up with the medication error. She stated she pulled up Electronic Health Record of Resident #157, looked at her photo, looked at Resident #155 sitting in the dining room and thought that Resident #155 was actually Resident #157. She stated she walked over to Resident #155 and asked her if she was (first name of Resident #157) and the resident replied yes. She said she told her she had pills for her and Resident #155 said ok and she took them. She stated again she had never met either resident. The Medication Error/Omission Report, dated 4/13/24, documented How this error could have been prevented Have identification on any wheelchair used by residents out of room. Ask resident name and date of birth before giving meds - 5 rights (The five rights of medication administration) The facility form Medication Error Process documented Why did this occur? Resident was not ID'd correctly. She answered to (other resident's name) and was in a wheelchair with no ID. Was not asked her name. The facility policy Administration of Medication, revision date of 6/28/23 documented the Standard of: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis.