

**Iowa Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

<b>Citation Number:</b> #6558		<b>Date:</b> June 8, 2017		
<b>Facility Name:</b> Woodward Resource Center	Fine amount reduced by 35% to \$3,250.00 on June 13, 2017 pursuant to Iowa Code Section 135C.43A	<b>Survey Dates:</b> May 9-30,2017		
<b>Facility Address/City/State/Zip</b> 1251 334 <sup>th</sup> Street Woodward, Iowa 50276				
	DS			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

64.60 + W104 + W368	<p><b>481—64.60 (135C)</b> Federal regulations adopted—conditions of participation. Regulations in 42 CFR Part 483, Subpart D, Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Classification of violations is I, II, and III, determined by the division using the provisions in 481—Chapter 56, “Fining and Citations,” to enforce a fine to cite a facility.</p> <p>This rule is intended to implement Iowa Code section 135C.2 (3).</p> <p><b>483.410(a)(1) Governing Body</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p><b>483.460(k)(1) Drug Administration</b> The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p><b>DESCRIPTION:</b></p>	I	\$5,000	Upon Receipt
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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	<p>Based on record review, staff interviews and review of protocols and policy and procedures, the facility's governing body failed to ensure staff consistently followed established protocols to ensure the health and safety of clients. Staff failed to follow the physician's order for administration of medication to Client #1 and failed to follow established protocols for the administration of Clozaril (an anti-psychotic and potentially dangerous medication). Due to the ingestion of another resident's medication (Clozaril), and prior administration of own medication, Client#1 required transport to the hospital and later returned to the facility medical center.</p> <p>Finding indicated:</p> <p>Record review on 5/9/16 revealed a Medication Variance Report, dated 4/26/17 for Client #1. According to the report, Client #1 received another client's dose of Clozaril. Further review revealed a Nursing Assessment, dated 4/26/17 at 9:02 a.m.; identified staff brought Client #1 to the medical center for observation. The client was transferred to the hospital for administration and/or ingestion of Clozaril. The assessment noted Client #1 had taken his/her prescribed medications prior to the ingestion of the Clozaril. According to the assessment Client #1 appeared</p>			

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	<p>drowsy and speech seemed more difficult to understand. Staff administered activated charcoal prior to arrival at the medical center, as required by policy. At 9:24 a.m. another assessment documented the staff transferred Client #1 to the hospital. The staff transferred Resident #1 onto a gurney and he/she left the facility medical center for the hospital at 9:30 a.m. The nursing staff completed an assessment at 4:15 p.m. According to the assessment Client #1 returned to the medical center from the hospital and appeared a little sleepy, difficult to understand but able to ambulate with standby assist. Client #1's parents were at his/her bedside and requested medications be held until tomorrow.</p> <p>Additional record review identified a nursing assessment, completed 4/26/17 at 9:00 a.m. The assessment documented Client #1 received another client's medications, which included: Clozaril 150 mg, Inderal mg, Lithium 750 mg, Clorazepate 15 mg; in addition to his/her own medications, which included: Depakote 750 mg, Klonipin 1.5 mg, and Cogentin 1.5 mg.</p> <p>When interviewed on 5/9/17 at 12:30 p.m. Staff A said she administered medications on 4/26/17 when Client #1 received 100 mg of Clozaril/clozapine. She confirmed Client #1</p>			

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	<p>received another client's Clozaril. She said the morning had been hectic and although the policy/protocol directed that Clozaril be passed first, the client to receive the medication would not get out of bed so she administered other client medications. She confirmed Staff B functioned as the "helper" to witness the administration of Clozaril per protocol. She said Staff B signed the "helper" checklist after she popped the pills and placed them in a medication cup. She said after Client #1 took the Clozaril she contacted the nurse and administered activated charcoal. Once the nurse arrived, Client #1 was sent to the medical center and then on to the hospital.</p> <p>When interviewed on 5/17/17 at 10:45 a.m. Staff B admitted he signed the "helper" checklist before visually identifying the correct person. Staff B stated he should have completed each step of the protocol before signing the items as completed. Staff B stated he could not say whether Client #1 grabbed the medications or Staff A handed the medications to Client #1.</p> <p>When interviewed on 5/9/17 at 1:00 p.m. Staff C (nurse) said Staff A called her to report Client #1 was given another client's Clozaril. Staff C said she asked Staff A why the Clozaril wasn't administered first per protocol and Staff A said the client who should have received the Clozaril</p>			

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	<p>would not get out of bed so Staff A administered other medications. Staff A confirmed Staff B should not have signed the "helper" checklist before he ensured the medication aide identified the correct person. She said Staff A told her that Staff B had signed off on the "helper" checklist before Client #1 received the Clozaril.</p> <p>Review on 5/17/17 of the document titled <b><u>Woodward Resource Center (WRC) Nursing Protocols</u></b>, identified nursing protocols which included and in bold letters the following:</p> <p><b>"Clozapine given to the wrong person may be fatal!"</b></p> <p>Client #1's diagnosis included bipolar disorder, intermittent explosive disorder, attention deficient hyperactivity disorder and moderate intellectual disabilities. Review on 5/17/17 of WRC Type 1 Incident Investigation report revealed Client #1 received the following medications prescribed for another client on 4/26/17, Clozaril (antipsychotic) 150 mg, Inderal 20 mg, Lithium (treats manic depression) 750 mg and Clorazepate (for anxiety and difficulty sleeping) 15mg. Staff A also administered Client #1's routine medications that included Depakote (for seizures) 750 mg, Klonopin (for seizures) 1.5 mg and Cogentin (for involuntary movements) 1.5 mg.</p>			

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	<p>Interviews and record review confirmed the "helper" signed off that all steps of the protocol had been completed without actually following and ensuring the steps had been followed. This resulted in Client #1 receiving Clozaril (clozapine) a potentially fatal medication not intended for the client. This posed as an additional safety threat when Client #1 had the accumulation of his/her own medications and the other resident's medications, including the Clozaril.</p> <p><b>FACILITY RESPONSE:</b></p>			
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