

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

Citation Number: # 6925		Date: February 28, 2019		
Facility Name: Kahl Home for the Aged & Infirm		Survey Dates: January 31 to February 14, 2019		
Facility Address/City/State/Zip: 6701 Jersey Ridge Road Davenport, IA 52807		MW/SS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
56.12(135C)	<b>481—56.12(135C) Class I violation as a result of multiple lesser violations.</b> The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.	I	\$ 7500.00	Upon Receipt
58.20(3)	<b>481—58.20(135C) Duties of health service supervisor.</b> Every nursing facility shall have a health service supervisor who shall: <b>58.20(3)</b> Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)			
58.21(15)c	<b>481—58.21(135C) Drugs, storage, and handling.</b> <b>58.21(15)</b> Drug administration. c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)  <b>DESCRIPTION:</b>  Based on clinical record review and resident, family member, staff, pharmacist and physician interviews, the facility failed to ensure that each resident remained free from undesired side effects from medications identified as allergens that resulted in pain, nausea, weight loss, overall decline and hospitalization for one of six residents reviewed (Resident #3). The facility			

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	<p>reported a census of 119 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment tool dated 12/28/18 recorded Resident #3 had diagnoses that included anemia, congestive heart failure, diabetes and asthma, a score of 15 out of 15 points possible on the Brief Interview of Mental Status (BIMS) cognitive assessment, without deficits or symptoms of delirium,. Resident #3 required the assistance of one to two staff for transfers to and from bed, dressing, toilet use, bathing and personal hygiene. The resident did not walk during the assessment lookback period.</p> <p>A hospital discharge summary dated 11/30/18 detailed the resident's hospitalization and treatment for syncope (fainting), head injury, left leg injury, diabetes, chronic atrial fibrillation (irregular heart beat), severe persistent orthostatic hypotension (blood pressure drop upon standing), generalized weakness and anemia. Chronic medical conditions included gastric cancer with surgical correction in 2012, and ulcerative colitis.</p> <p>A hospital universal transfer form dated 11/30/18 directed to transfer Resident #3 to the facility and medication administration that included sulfasalazine (a combination of salicylate and Sulfa antibiotic medication, labeled as an anti-inflammatory medication for ulcerative colitis) 1000 milligrams (mg) administered orally three times daily. The 11/30/18</p>			

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	<p>universal transfer form also listed the following medication allergies and reactions:</p> <ul style="list-style-type: none"> <li>a. Salicylates (a component of aspirin) - abdominal pain.</li> <li>b. Bactrim (a sulfa-based antibiotic) - rash.</li> <li>c. Sulfa drugs - nausea.</li> <li>d. Aspirin - no reaction listed.</li> </ul> <p>A warning/alert message on 11/30/18 at 7:40 p.m. in the electronic record, addressed to Staff A, registered nurse (RN) and author of the order entry the system identified a possible drug allergy for the following order: Sulfasalazine 500 mg tablet, give 2 tablets by mouth 3 times a day for bowel health.</p> <p>The resident's Medication Administration Record, (MAR) listed allergies that included Sulfa antibiotics, salicylates and aspirin and documented Resident #3 received Sulfasalazine 3 times a day as ordered from 11/30/18 through 12/31/18 with the following omissions:</p> <ul style="list-style-type: none"> <li>a. 12/5/18 refused at 8:00 a.m.</li> <li>b. 12/6/18 refused at 8:00 a.m.</li> <li>c. 12/7/18 at 12:00 p.m. when hospitalized.</li> <li>d. 12/23/18 at 8:00 p.m. through 12/27/18 at 8:00 p.m., when a physician ordered staff to withhold the medication pending review by the primary care physician.</li> <li>e. 12/28/18 refused at 8:00 a.m.</li> <li>f. 12/28/18 out of facility at 12:00 p.m.</li> <li>g. 12/30/18 refused all doses.</li> <li>h. 12/31/18 refused at 8:00 p.m.</li> </ul>			

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	<p>A Nurse's Note (NN) transcribed by Staff B, RN (Registered Nurse) on 12/2/18 at 6:35 p.m. recorded Resident #3 stated he had not felt good since the day before, with nausea, upset stomach, loose stools, and felt like he had the flu.</p> <p>A physician order on 12/3/18 at 11:45 a.m. directed staff to administer Zofran (an antiemetic medication) 4 mg orally every 6 hours as needed for nausea or vomiting. The MAR recorded staff administered Zofran on 12/4/18 at 4:04 p.m., 12/5/18 at 10:55 a.m. and 12/6/18 at 9:02 a.m.</p> <p>On 12/7/18 at 11:40 a.m., a nurse practitioner assessed the resident, concerned about continued nausea, dizziness and headaches with movement, and ordered the resident's transfer to the Emergency Room (ER).</p> <p>The 12/7/18 ER record described the resident treated for conditions that included recurrent nausea, general stomach ache and abdominal pain. Abdominal X-rays obtained then did not reveal any gastric or abdominal abnormalities.</p> <p>A 12/10/18 NN transcribed at 6:06 p.m. by Staff C, licensed practical nurse (LPN), documented Resident #3 had continued nausea with poor appetite.</p> <p>On 12/11/18 at 11:45 a.m., the Zofran order was increased to 8 mg administered orally every 6 hours as</p>			

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	<p>needed for nausea or vomiting. The MAR recorded staff administered Zofran 8 mg on 12/11/18 at 12:32 p.m., 12/12/18 at 8:49 p.m. and 12/24/18 at 10:59 a.m.</p> <p>A 12/13/18 visit note transcribed by the NP recorded the resident had continued bouts of nausea, directed staff to continue to administer Zofran as needed and added an order for Compazine (an antiemetic medication) 10 mg orally every 6 hours as needed for nausea or dizziness and staff instruction to monitor the resident's condition.</p> <p>A NN transcribed on 12/15/18 at 6:45 p.m. by Staff B reported the resident's stomach upset and poor appetite.</p> <p>A NN transcribed on 12/19/18 at 3:44 p.m. by Staff C documented continued nausea with a poor appetite.</p> <p>A visit note transcribed by the NP on 12/19/18 described continued nausea with temporary relief from Zofran, his oral intake impacted by nausea, the resident had continued loose stools without abdominal pain, and directed staff to schedule an appointment with the resident's gastroenterologist for follow-up.</p> <p>A NN transcribed by Staff C on 12/20/18 at 3:49 p.m. described the resident's continued nausea with poor appetite.</p> <p>A NN transcribed by Staff D, LPN, on 12/23/18 at 1:36 p.m., documented Resident #3 had continued nausea.</p>			

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	<p>When she administered his noon medications she noticed the resident's listed Sulfa allergy on the MAR and his prescribed Sulfasalazine. The resident reported stomach upset was one of the symptoms of the allergy and he had been nauseated for a few weeks. She contacted the on-call physician and obtained an order to hold the Sulfasalazine until his primary care physician could evaluate the resident.</p> <p>A visit note transcribed by the NP on 12/27/18 recorded Resident #3 stated he felt a little bit better that day, with a continued poor appetite but food intake slightly increased, no complaints of abdominal pain, and directed staff to resume administration of Sulfasalazine.</p> <p>A computed tomography (CT) scan of the abdomen performed 12/28/18 revealed the test ordered for the resident's abdominal pain with diarrhea and bloating symptoms for about a month. The scan did not reveal any current abnormalities of concern related to the abdomen or stomach.</p> <p>A facsimile (fax) document addressed to the physician on 1/1/19 requested discontinuation of Sulfasalazine due to constant daily refusals, and listed allergies that included Sulfa antibiotics, salicylates and aspirin. The returned fax on 1/2/19 ordered the medication discontinued.</p> <p>A NN transcribed on 1/3/19 at 7:10 p.m., described the resident as pulseless, breathless, cardiopulmonary</p>			

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	<p>resuscitation (CPR) initiated, 911 activated and the resident transferred to the ER.</p> <p>Recorded resident weights included:</p> <p>12/1/18 227.0 pounds (#)          12/2/18 227.7#          12/3/18 227.5#          12/4/18 226.8#          12/5/18 210.6#          12/10/18 210.4#          12/11/18 214.0#          12/13/18 214.8#          12/14/18 213.0#          12/15/18 213.8#          12/16/18 213.0#          12/17/18 213.8#          12/18/18 211.9#          12/19/18 212.0#          12/20/18 213.0#          12/21/18 213.6#          12/23/18 214.2#          12/24/18 213.8#          12/25/18 213.5#          12/26/18 213.5#          12/27/18 210.8#          12/28/18 211.6#          12/29/18 211.0#          12/30/18 211.9#          12/31/18 210.6#          1/1/19 207.4#          1/2/19 208.0#          1/3/19 208.0#</p>			

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	<p>On 2/12/19 at 1:01 p.m., the resident's gastroenterologist stated in the past, he prescribed Sulfasalazine but discontinued the medication due to the resident's Sulfa allergy. Resident #3 complained of abdominal pain and nausea, had been prescribed Apriso then (an anti-inflammatory medication for the treatment of ulcerative colitis), he had not been consulted about the resident's conditions while at the facility, and Sulfasalazine and Apriso medications should not be administered concurrently. One or the other medication should be prescribed to treat the targeted symptoms, but not both.</p> <p>On 2/4/19 at 1:46 p.m., a pharmacist at the resident's retail pharmacy (utilized before hospitalization and admission to the facility) stated Resident #3 had not refilled the Sulfasalazine medication since March, 2018 and Sulfa was not listed as an allergy. During a second interview on 2/5/19 at 8:55 a.m., a pharmacist confirmed a Sulfa allergy was not listed and stated someone allergic to Sulfa should not take Sulfasalazine.</p> <p>On 2/7/19 at 12:44 p.m., the facility's NP stated she reviewed admission referrals with medication orders for residents admitted to the facility's Medical Director. She could make changes to the medication regimen, meet with the resident and/or family, clarify conditions and allergies at that time, but Resident #3 was under the care of a different physician group who would have had that responsibility.</p>			

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	<p>Upon request on 2/4/19, staff could not locate the resident's admission orders with physician signature. On 2/11/19, Staff G, LPN and unit manager, stated they were not able to locate the document. The document would list allergies, medical conditions, medications, treatments ordered, and physician signature mandated for admissions to facilities for skilled level of care.</p> <p>On 2/4/19 at 2:31 p.m., Staff A, RN and evening supervisor, stated when pharmacy identified a medication conflict or allergy, the nurse or pharmacy could resolve that with the provider. He had not contacted the provider when he was alerted of the potential Sulfasalazine allergy on 11/30/18, the pharmacy took care of it and if the nurse clarified the order they would document that in the NN.</p> <p>On 2/5/19 at 12:10 p.m., Staff I, LPN, stated if a nurse received notice of potential medication allergies in the resident's electronic record, they should review and clarify it with the provider, then document the action in the NN.</p> <p>On 2/5/19 at 12:25 p.m., Staff F, LPN and unit manager, stated the nurse was notified of a potential medication allergy in the electronic record. She normally clarified it with the provider, sometimes made a note about it, and the facility NP verified orders. In a subsequent interview on 2/5/19 at 12:32 p.m., Staff F stated their NP signed all physician order sets (POS's)</p>			

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	<p>and her training made her responsible for the final check for drug safety or potential allergic reaction.</p> <p>On 2/4/19 at 2:10 p.m., Staff C, LPN, stated the nurse should contact the provider to clarify if alerted of a medication allergy by the pharmacy, and document that in the NN. Resident #3 had a lot of gastrointestinal issues, lots of nausea, went to the ER a few times and always came back with nothing; the Zofran didn't help, nothing helped. Staff C stated she went through his medication list with his spouse, she said he was allergic to the Sulfasalazine so they discontinued it.</p> <p>On 2/4/19 at 1:58 p.m., the Director of Nursing (DON) stated she wasn't sure what staff did to clarify orders if there was a conflict or potential drug allergy. The DON expected staff to clarify it with the provider but didn't think they wrote an order about it. At 2:44 p.m. the DON stated she spoke with the nurses and if they identified an allergy, they consulted with the provider and documented in the NN, they would write an order only if it changed the original order.</p> <p>On 2/4/19 at 1:32 p.m., the facility's consultant pharmacist stated staff are alerted of potential medication allergies through the electronic record after medication orders were entered, nursing staff were supposed to clarify the matter with the physician and the pharmacy was not involved in that process.</p> <p>The Medication Regimen &amp; Review policy, dated</p>			

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	<p>1/31/18 and without approval signatures, recorded a drug regimen review is conducted upon admission and throughout the stay. When potential clinically significant medication issues are identified the facility will address the issue in a timely manner. The admission nurse was responsible for medication reconciliation and identification of potential clinically significant medication issues upon the resident's admission.</p> <p>The Medication Allergy Identification and Procedure policy, without signatures, dated 2/6/19 and provided on 2/7/19 at 12:40 p.m., recorded that a drug regimen review is conducted upon admission and throughout the resident's stay. Potential drug allergies will be addressed with the physician/NP. Orders will be obtained if it is determined the medication has potential risks and should be discontinued. The initial time the allergy warning appears on the MAR the nurse administering will consult with the physician/NP, if not done before. The nurse will document the results of the conversation in the medical record.</p> <p>The facility's policy and procedure manuals provided on 2/7/19 at 1:11 p.m., contained the following documents:</p> <p>a. A nursing Administering Medications policy, dated and signed by the previous administrator on 6/11/08, which directed nursing staff to verify medication allergies prior to medication administration, and if a medication was withheld, staff were to document the event with rationale in the NN and notify physician.</p>			

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	<p>b. A Nursing Service: Medication Reconciliation policy, dated and signed by the previous administrator and current DON on 3/20/17, directed that each resident's drug regimen was free from unnecessary drugs that included the presence of adverse consequences which indicated the dose should be reduced or discontinued, clinically significant adverse consequences would be minimized, and the potential contribution of the medication regimen to an unanticipated decline or newly emerged or worsened symptom would be recognized and evaluated, and the regimen modified when appropriate. Nurses were to document physician notification and verification of admission orders and clarification of all discrepancies in the NN.</p> <p>b. A nursing Medication Regimen &amp; Review policy, dated and signed by the current administrator and DON 8/14/17, directed the consultant pharmacist's monthly review of resident medication regimens that included the medical record, and written reports required and directed to the physician, facility medical director and DON, for any irregularity that required action. The written report was to detail the relevant medication irregularity. If the identified irregularity required urgent action, the consultant pharmacist would report the irregularity to the DON and attending physician by phone, with a separate written report to the physician, medical director and DON. The physician was required to document any follow up action necessary in the resident record within 10 days of the report.</p>			
	On 2/14/19 at 8:46 a.m., Staff J, responsible for			

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	<p>mission integration, and Staff K, responsible for infection control and QAPI, (Quality Assurance and Performance Improvement), stated facility policies and procedures were reviewed at least annually, revised when appropriate, dated when reviewed, signed by the administrator and located in manuals accessible to staff. They had not seen the unsigned policies before and Staff J questioned where they came from.</p> <p>On 2/6/19 at 5:53 p.m., Staff E, RN, stated the policy and procedure manuals were in the inservice director's office, nurses had access to them in the office and they were not located on the nursing units or electronically on the computer.</p> <p>On 2/13/19 at 1:31 p.m., Staff D, LPN, stated she worked on 12/23/18. She prepared his ordered medications, Resident #3 asked what they were, he said he was allergic to the medication, she asked what his symptoms were and he said it made him nauseous and upset his stomach. She was informed in report that day that he'd been nauseous and had received antiemetic medications almost as long as he had been there. She called the on-call physician and obtained an order to hold the Sulfasalazine.</p> <p>On 2/6/19 at 11:25 a.m., Staff H, LPN and unit manager, stated Staff D was not familiar with the resident's physician group, obtained the order to hold the Sulfasalazine from the wrong physician, and one of the NP's in the resident's physician group said to disregard the order since it wasn't made through their</p>			

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	<p>provider group.</p> <p>On 2/7/19 at 2:04 p.m., the facility's consultant pharmacist stated he reviewed the resident's medical records, medication orders and allergies when he performed the medication regimen review on 12/3/18. Sulfasalazine was listed as a home medication, the resident had been at the facility for 4 days, staff didn't identify any particular problems when he asked, at that point there wasn't an indication to modify the order, the facility didn't document medication allergy verses intolerance, and many medications cause nausea. His note would have addressed the allergy if there was a concern at the time.</p> <p>On 2/5/19 at 8:30 a.m., the resident's family member stated the gastroenterologist put Resident #3 on Apriso and took him off the Sulfasalazine because he was allergic to Sulfa. Facility staff didn't tell the resident what medications they gave, informed he was on Anoro and Sulfasalazine when she asked, and she told staff he was allergic to both medications. The resident was nauseous, had stomach pain and didn't feel good during every visit.</p> <p><b>Facility Response:</b></p>			