

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

Citation Number: 7083		Fine Amount Reduced by 35% to \$2,437.50 on February 03, 2020 pursuant to Iowa Code Section 135C.43A		Date: January 6, 2020	
Facility Name: Courage Homes		Survey Dates: October 29-31, 2019			
Facility Address/City/State/Zip 5945 Morningside Avenue Sioux City IA 51106		MW			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

64.60(135C)	<p>481—64.60(135C) 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.</p> <p>Classification of violations is I, II, and III, determined by the division using the provisions in <u>481—Chapter 56</u>, “Fining and Citations,” to enforce a fine to cite a facility.</p> <p>This rule is intended to implement Iowa Code section <u>135C.2(3)</u>.</p>	I	\$2250.00	UPON RECEIPT
W368	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>DESCRIPTION:</p> <p>Based on interview and record review, the facility failed to ensure all medications were given in accordance with Physician Orders. This affected</p>			

Facility Administrator

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	<p>1 of 1 client (Client #2) involved in the investigation of #86832-I. Finding follows:</p> <p>Record review on 10/29/19 revealed a facility internal investigation, initiated 10/11/19. The internal investigation noted on 10/11/19 during the 8:00 p.m. medication pass, Licensed Practical Nurse (LPN) A gave Client #2, Client #3's medication. Client #2 was prescribed rantidine 150 milligrams (mg), calcium carbonate/D 600/400mg, Miralax 30cc in water, liquid ferrouse sulfate 220mg, and Clozaril 25 mg at the 8:00 p.m. medication pass but received Keppra 1500 mg, Risperdal 1mg, Trazadone 50mg, Vimpat 200mg, Lamictal 300mg, and Potassium Citrate 1080mg. LPN A called the on-call physician who instructed to have Client #2 taken to the Emergency Room by ambulance in case Client #2 would become unstable. At the Emergency Room, labs were drawn and Client #2 was given IV fluids. Client #2 did vomit while at the Emergency Room and was given Zofran and a Compazine suppository. Client #2 remained in the Emergency Room for approximately four hours for observation then returned to the facility. Nursing continued to monitor Client #2 and documented from 10/12/19 - 10/15/19 Client #2 had no further emesis and was acting per her normal self.</p>			
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	<p>Continued record review revealed Client #2 was 37 years old and had resided at the facility since 3/18/91. Client #2 was diagnosed with but not limited to an Intellectual Disability, dymorphoic syndrome, status post femoral varus, derotational osteotome, history of a seizure disorder, esophagitis, constipation DUB, and anemia unspecified origin. Client #2 had no programs or procedures in place for medication administration.</p> <p>Additional record review revealed Client #2's Physician Orders, dated 8/1/19 - 10/31/19. The orders instructed Client #2 was to receive Zantac (rantidine) 150 mg, Calcium with Vitamin D (calcium carbonate/D) 600/400mg, Miralax 30cc in water, liquid Ferrouse Sulfate 220mg, and Clozaril 25 mg at the 8:00 p.m. medication pass.</p> <p>Review of Client #3's Physician Orders, dated 8/1/19 - 10/31/19, instructed Client #3 was to receive Trazadone 50 mg, Risperdal 1 mg, Lamictal 300 mg, Potassium Citrate Extended Release 1080 mg, Keppra 1500 mg, and Vimpat 200 mg at the 8:00 p.m. medication pass.</p> <p>When interviewed on 10/30/19 at 1:30 p.m., LPN A reported on 10/11/19 worked the second shift at the facility. She said she finished assisting in the small dining room and went to start the 8:00 p.m.</p>			
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	<p>medication pass. LPN A said she went into the medication room and prepared Client #2 and Client #3's medication. She brought the prepared medications out to the clients and assisted Client #2 with taking her medication. She stated as she was getting ready to assist Client #3 with his medication, she realized she had given Client #2, Client #3's medications. LPN A said she kept Client #2 with her and immediately called the on-call doctor. She said the doctor called the pharmacist and poison control then called back to the facility and instructed her to send Client #2 to the Emergency Room, by ambulance in case Client #2 became unstable during transport. LPN A said she went to the Emergency Room and Client #2 was started on IV fluids. She said Client #2 did vomit, on her own, while in the Emergency Room, and was given Zofran and a suppository. Client #2 remained in the Emergency Room for observation for approximately four hours before she was discharged. LPN A said there was no excuse for her medication error. She said the facility had policies and protocols, which she was trained on, to bring each client to the medication room during medication passes and have each client assist with the process. She said in her own mind she thought she needed to get the medication pass completed but said again there was no excuse for the error.</p>			
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	<p>Additional record review revealed notes from a Nurses Meeting, dated 5/15/19, which LPN A was in attendance. The meeting notes included instruction to make sure medications were always set-up in front of the client and medications were not to be given to clients in the hallways, dining room, etc. The meeting notes also included the proper medication pass was reviewed during the meeting.</p> <p>Review of facility policies revealed the "ICF/ID Health Care Services: Policies and Procedures," last updated 5/16. The section titled "Medication Administration Procedure" instructed each client was to be an active part of each of their medication passes, each client was to be prompted one at a time to the medication room and were to be prompted to get their own medications and own drink, and each client was to assist with putting their medications away after the medication pass was completed.</p> <p>FACILITY RESPONSE:</p>			
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56.6(1)	<p>481—56.6(135C) Treble and double fines.</p> <p>56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.</p>			

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W153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>DESCRIPTION:</p> <p>Based on interview and record review, facility staff failed to immediately report an allegation of client mistreatment and/or abuse to the supervisor/administrator, per facility policy. This affected 1 of 1 client (Client #1) involved in the investigation of #86463-I. Finding follows:</p> <p>Record review on 10/29/19 revealed a facility internal investigation, initiated 10/8/19. The internal investigation noted on 10/8/19 Cook A reported to the Administrator on 10/6/19 at approximately 5:20 a.m. Client #1 had been banging his head so he assisted Residential Living Assistant (RLA) A to get Client #1 off the floor. Co A said RLA B entered the living room and picked up Client #1 from a chair,</p>			
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	<p>commented she was not playing his game, and walked Client #1 toward his bedroom.</p> <p>Additional record review revealed Client #1 was 35 years old and had resided at the facility since 10/24/89. Client #1 was diagnosed with but not limited to a severe intellectual disability, bilateral sensorineural hearing loss, seizure disorder, microcephaly, asthma, and osteoporosis. Client #1 had an Individual Program Plan (IPP) in place to address inappropriate night-time behaviors which included self-injurious behaviors and disruptive behaviors. The IPP instructed staff to sign "stop" and block any self-injurious behaviors. If Client #1 left his room during the night, staff were to sign "bed" and assist him to bed. Staff were to sit outside his door for fifteen minutes when he first retired to bed. If Client #1 attempted to leave his bedroom or engaged in self-injurious behaviors, staff were to redirect him back to bed. Throughout the night, if Client #1 attempted to leave his room, staff were to go to his room, direct him back to bed, and sit outside of his bedroom for five minutes. If Client #1 continued to attempt to leave his bedroom, staff were to</p>			
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	<p>continue to direct Client #1 back to his bedroom and after ten minutes, staff were to monitor outside his door. Restrictions utilized in conjunction with the IPP included the use of a bedroom door alarm, a window alarm, his bathroom door was locked, and the sink water was able to be shut off.</p> <p>When interviewed on 10/29/19 at approximately 1:20 p.m., the Administrator confirmed Cook A did not immediately report concerns of client mistreatment and/or abuse per facility policy. The Administrator explained Cook A did not report the concerns until 10/8/19, two days after the incident occurred.</p> <p>When interviewed on 10/30/19 at 9:15 a.m., Cook A said on 10/6/19 at approximately 5:20 a.m. Client #1 was running from RLA A and then dropped to the ground and started to bang his head. Cook A said he assisted RLA A to get Client #1 off the floor and walked with Client #1 to the living room; Client #1 sat in a recliner. Cook A said RLA B then entered the living room, "snatched" Client #1 up and said she was not "playing his damn game this</p>			
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	<p>morning." Cook A said RLA B then walked behind Client #1, with her hand on his back, toward his bedroom. Cook A explained RLA B grabbed Client #1 by the shirt/shoulder area when she "snatched" Client #1 up; Client #1 stood up by himself and walked toward his bedroom while RLA B walked behind him. Cook A said he reported the incident to his supervisor later on 10/6/19. When asked if supervisors worked on the weekend, Cook A said his supervisor did not work so he must have reported the incident the following day on 10/7/19.</p> <p>Review of facility policies revealed the "Mid-Step Services Inc. Child and Dependent Adult Abuse Policy," last revised 8/2/17. The policy instructed, "staff are required to report any incident or situation in which they reasonably believe the member has suffered abuse or mistreatment. If an employee of Mid-Step Services witnesses an incident, has a suspicion, or reasonably believes a member has suffered abuse, the employee is required to take immediate steps to ensure that the suspected abuse is stopped, then report directly to the administrator, supervisor, on-</p>			
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	<p>duty administrator, and the appropriate regulatory agency ..." The policy continued to instruct, "All employees are required to report any apparent abuse or mishandling of members. Reports are to be immediately after they occurred or the staff member became aware of the incident. Reports of suspected abuse must be made immediately to both the supervisor/administrative officer and to the appropriate regulatory department ...".</p> <p>Review of the "Reporting and Investigation (ICF/ID)," dated 5/11/18, instructed all employees were required to report any suspected abuse or mishandling of a client immediately after the incident or becoming aware of the incident to the supervisor/administrative officer.</p>			
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