Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 8009	**Fine Amount reduced by 35% to $10,725.00 on March 02, 2020 pursuant to Iowa Code Section 135C.43A**	**Date:** February 18, 2020
Facility Name: Park View Homes		**Survey Dates:** January 6-9, 2020
Facility Address/City/State/Zip 2815 Lincoln Way Sioux City, IA 51106	MW	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60(135C)	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. 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. This rule is intended to implement Iowa Code section 135C.2(3).	I	$16,500 (treble)	UPON RECEIPT
56.6(1)	481—56.6 (135C) Treble and double fines. 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.			

Facility Administrator _____ Date _____

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W368	**The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.** **DESCRIPTION:** Based on interviews and record reviews, the facility failed to administer medications in according to with physician orders. This affected 1 of 1 Client (Client #14) reviewed during investigation #87739-I. Finding follows: Record Review on 1/6/20 revealed a Medication Incident Report, dated 1/1/20 at 7:00 a.m., written by Registered Nurse (RN) A. The report noted "Client #15 called to the med room for meds, I grabbed med bin and began putting out medications for Client #15. Client #15 set up his medications in a plastic cup and walked out of the medication room before taking them." RN A further noted he went to get Client #15 to finish medication administration when Client #14 approached the med room. He then asked Client #14 if he wanted to take his medications. Client #14 entered the med room and RN A began to prepare Client #14's MiraLax/Lactulose drink. As he did this Client #14 took Client #15's meds from the counter and swallowed them.			

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	Continued record review revealed a 1/1/20 Interdisciplinary Progress Note written by RN B which noted the Physician had been called due to Client #14 being unbalanced in his chair, slumped down and unable to remain upright. Client #14 then became unresponsive and 911 was called. According to Client #14's Physicians Form, Client #14's current a.m. medications included: Senna-S Tablet, Divalproex Tab 500 Mg Dr, Levothyroxine Tab 137 Mcg, Risperidone Tab .25 Mg, Selenium Sul Sha 2.5%, Therems-M tab, Dilantin Cap 30 mg, Metoprolol tab 100 Mg ER, Sertraline Tab 100 Mg, Chlorex Glu Sol .12%, Phenytoin Er Cap 100 mg, Ammonium Lac lot 12%, Calcium Carb-D, Constulose Sol 10 Gm/15ml, Nystatin Pow 100000, Polyeth Glycol 3350 Pow, Retin-A Cre 0.05%. According to Client #15's Physicians Form, Client #15's current a.m. medications included: Bupropion Hcl xl 150 Mg Tab, Ferrous Sulfate Tab 325 Mg, Fluoxetine Cap 20 mg, Folic Acis 1 Mg Tab, Multivitamin Tab, Clozapine 25 Mg Tablet, Clozapine 100 Mg Tablet, Debrox Sol 6.5% OT, Primadone Tab 50 Mg. Continued record review on 1/6/20 revealed Client #14's after visit summary from his Unity Point Emergency Revisit dated 1/1/20. The			

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	Summary indicated Client #14, a 52 year old male, accidentally received another resident's medication. The medication included folic acid, multivitamin, Primidone, Clozapine, Iron, Prozac and Wellbutrin. The patient was normally fully awake but appeared very sleepy. He had yet to receive his normal medications. Staff denied any fall/injury or vomiting. Vitals read: temperature, 98.4 F; heart rate 70; blood pressure 132/83. Upon arrival at the emergency room Client #14 was not in respiratory distress. His heart rate was normal and he was not in distress. The Client became more responsive at the emergency room and was eventually discharged at 6:16 p.m. Further review on 1/6/19 at 3:00 p.m. revealed RN A trained on the facility policy for medication administration. The medication policy directed the following: Have available the Medication Administration Record (MAR) for the consumer and the consumer's medication. The MAR and medication should be compared to insure that they are the same. Continued review revealed RN A had also been trained on the six rights of medication administration: right person, medication, dose, route, time and documentation.			

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	When interviewed on 1/7/20 at 8:15 a.m. RN A stated he did not use the (MAR) during medication administration with Client #14. He stated he turned around setting up the liquid medication for Client #14 and when he turned around Client #14 took medication in a plastic cup on the counter that belonged to Client #15. At the time he didn't realize Client #14 had just taken the medications he previously set up for Client #15. RN A stated approximately 15-25 minutes later Client #15 returned to the med room and asked for his meds he set up just prior. He stated at this time he realized Client #14 probably received Client #15's medications. He admitted he gave the wrong medication to Client #14. He confirmed he failed to administer medications according to physician orders and follow policy and procedure. He admitted he "made a mistake." **FACILITY RESPONSE:**			

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