

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

Citation Number: 9016					Date: October 14, 2020
Facility Name: Glen Oaks Alzheimer's Special Care Center		Survey Dates: July 14 -23, 2020			
Facility Address/City/State/Zip 8525 Urbandale Avenue Urbandale, IA 50322					
		LK	88954-C, 89343-C, 89937-C		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

57.11(7)	<p>DESCRIPTION:</p> <p>57.11(7) Orders for medications and treatments. Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III)</p> <p>Based on interview and record review the facility failed to follow primary care provider (PCP) orders for 1 of 5 former residents reviewed (Resident C-1). Findings include:</p> <p>Record review revealed Resident C-1 was admitted to the facility on 3/23/18 with diagnoses including dementia, hypertension, history of transient ischemic attacks (TIAs) and chronic atrial fibrillation (Afib). The resident was on an anticoagulation medication (Eliquis) to prevent blood clots. Record review revealed Resident C-1 had been taking a 5 mg. tablet of Eliquis at 8:00 a.m. and 5:00 p.m. daily until 2/08/20.</p> <p>Review of Resident C-1's quarterly orders dated 11/24/19 revealed routine orders for</p>	I	\$7,000.00	Upon Receipt
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Facility Administrator

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	<p>the following: APAP 325 mg. two tablets at 8:00 a.m. and 5:00 p.m.; Eliquis 5mg. at 8:00 a.m. and 5:00 p.m.; Amlodipine 5mg, at 8:00 a.m.; Atenolol 50mg.at 8:00 a.m.; Lisinopril 30mg at 8:00 a.m.; Furosemide 20mg at 8:00a.m.; POT CL Micro 20MEQ ER at 8:00 a.m.; and Vitamin D2 once weekly on Saturday at 8:00 a.m.</p> <p>On 7/14/20 review of Resident C-1's Medication Administration Record (MAR) for February 2020 revealed the Eliquis, Amlodipine, Atenolol, and Lisinopril were all stopped on 2/8/20. Orders to stop the administration of these drugs could not be located.</p> <p>On 7/14/20 a review of Progress Notes review revealed on the morning of 3/05/20 at 8:20 a.m. staff called the nurse into the dining room as Resident C-1 was having trouble speaking. The nurse's evaluation noted left side facial droop, word salad and left sided weakness. The resident's family agreed to have her sent to the emergency room by ambulance for evaluation. The emergency room's medical records revealed</p>			
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	<p>Resident C-1 suffered an Ischemic Stroke - precerebral occlusion. The emergency room physician noted the resident was prescribed Eliquis but had not been getting it at the facility. While in the emergency room Resident C-1 was given a tissue plasminogen activator (TPA) treatment. She started to have acute neurological changes such as not being able to follow commands and having a right upward gaze. A CT scan of her head showed a new small bleed. Resident C-1 passed away on 3/07/20.</p> <p>On 2/13/20 Resident C-1 had been seen by her PCP who documented her medications "reviewed and unchanged." This documentation came days after Resident C-1's medications had been discontinued as noted on the February MAR.</p> <p>On 7/16/20 at 10:21 a.m. an interview was conducted with the PCP to clarify what was meant by medications "reviewed and unchanged" as documented on her note dated 2/13/20. The PCP reported she had reviewed her last set of orders on her computer which were dated 11/24/19 and</p>				
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	<p>made no changes. She did not review the February MAR. She reported she had no idea the drugs had been stopped and confirmed she had not written orders to discontinue any of the medications, including Eliquis, that were stopped on 2/8/20. She reported that if the resident's cerebral vascular accident (CVA) was the result of a blood clot then stopping the Eliquis might have been a possible cause.</p> <p>The investigation revealed the facility utilized a computer program called Care Suite by QuickMAR for medication administration. Record review revealed the pharmacy renewed Resident C-1's scripts for Eliquis, Amlodipine, Atenolol and Lisinopril on 2/8/19. The original scripts were dated 3/23/18. There were no stop dates listed on the scripts. When entering the updated scripts into the computer on 2/8/19 former Staff D (an RN) inadvertently entered a stop date of one year for those medications. As a result, the computer automatically stopped those meds on the MAR on 2/8/20 and marked them as discontinued.</p>			
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	<p>On 7/21/20 at 11:12 a.m. interview with the former Administrator revealed the computer system required the user to put in an end date for each script as it was entered. The established standard of practice consisted of entering the medication end dates several years out in order to ensure the system did not stop any scripts before they were up. Scripts had to be renewed by PCPs at least annually.</p> <p>On 7/22/20 at 7:00 p.m. interview with former Staff D, who had been the Health Services Director in February 2019, revealed he could not remember or explain why he had put in a one year end date for the meds that were discontinued.</p> <p>On 7/22/20 at 11:25 a.m. interview with Staff G revealed she administered Eliquis, Amlodipine, Atenolol and Lisinopril to Resident C-1 on 2/7/20. She reported the computer system automatically alerted the user when a medication was expiring 3 to 4 days in advance. Staff G confirmed the computer alerted her the drugs she was passing that morning were expiring. She</p>				
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	<p>could not understand why these meds were expiring and reported this to her supervisor, former Staff E (LPN) who was seated at the computer in the nurses' office at the time. She stated former Staff E told her she "would get to it." Staff G had not documented this conversation with former Staff E and reported there were no witnesses in the area. Following the conversation, Staff G returned to passing medications. Staff G said she was not authorized to check or enter orders into the computer system. She only administered medications the computer told her to give. Unlike the paper MARs, a medication discontinued in the computer system no longer showed up on the pop up screen. Med passers could not see when medications were discontinued or why.</p> <p>Interview with former Staff E on 7/22/20 at 3:15 p.m. revealed she could not remember Resident C-1 having discontinued medications in February 2020 or pulling any discontinued medication from the cart for return to the pharmacy. She denied the conversation with Staff G took place and indicated Staff G "had it out" for her.</p>			
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	<p>Review of former Staff E's time card revealed she did not work on 2/7/20, 2/8/20, 2/9/20 or 2/10/20.</p> <p>On 7/30/20 at 11:30 a.m. the Director of Operations confirmed these findings and suggested talking with Staff M who had reported she recalled seeing Resident C-1's medication cards in the med cart when there were no computer prompts to pass the medication.</p> <p>On 7/30/20 at 3:00 p.m. Staff M stated she recalled seeing Resident C-1's medication cards in the med cart but there were no computer prompts to pass the meds. She thought this would have been in the morning, but could not give a specific date. Staff M said she also reported this to former Staff E but had not documented it and could not recall specifics of the conversation.</p> <p>Observation of the med cart revealed no medications for Resident C-1. No documentation could be located as to who removed them. The whereabouts of the</p>			
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57.34(135C) (3)(c)	<p>medications discontinued on 2/8/20 could not be determined.</p> <p>481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III)</p> <p>57.34(3) Resident safety.</p> <p>c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III)</p> <p>Based on interview and record review record review the facility failed to provide adequate supervision to ensure against hazards for 1 of 5 former residents reviewed (Resident C-2). Findings include:</p> <p>On 7/14/20 record review revealed Resident C-2 was admitted on 6/14/19 and passed away at the facility on 1/27/20. Progress notes review revealed Resident C-2 had falls</p>			
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	<p>on 12/21/19, 12/24/19, 1/21/20 (twice) and 1/23/20 (twice, one of which resulted in injury). As a result of the increased number of falls a fall mat had been positioned at the edge of the resident's bed. Intermittent 1:1 supervision was provided depending on the resident's level of anxiety. Hospice services were started on 12/19/19.</p> <p>A progress note dated 1/31/20 (late entry for 1/23/20) revealed that at approximately 6:00 p.m. on 1/23/20. Resident C-2 was found by Staff M sitting in a bookshelf with shattered glass around her. An open wound was observed on her right forehead. The epidermis and dermal layers were open. She had a dried stream of blood on her face. There was no active bleeding. The resident's PCP (primary care provider) was contacted agreed to not send her to the emergency room due to her current status (transitioning, hallucinations, panic from sounds and touch) and the POA's (power of attorney) wishes. The nurse cleaned the wound and applied steri-strips.</p>			
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	<p>On 1/24/20, the resident's PCP completed an established patient visit at the facility. The Metro Geriatric Services encounter note dated 1/24/20 documented the previous day the resident had multiple including one where she shattered glass on a cabinet she pulled on herself. The resident had a "large open wound on forehead, scalp open skull exposed. Blood controlled with intervention. She is now in bed, apnea episodes."</p> <p>On the morning of 1/23/20 Resident C-2's hospice nurse documented he had spent quite a bit of 1:1 time with the resident to keep her safe as she made multiple attempts to get up from her chair.</p> <p>A progress note dated 1/21/20 documented increased anxiety and agitation most of the 6:00 p.m. to 6:00 a.m. shift requiring 1:1 supervision most of the shift. The resident experienced increased hallucinations. She continually tried to stand and walk and called out to her mom and dad for help.</p> <p>On 7/22/20 at 9:15 a.m. former Staff C (Health Services Director) confirmed</p>			
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	<p>Resident C-2 needed 1:1 care before the fall on 1/23/20 but the former administrator did not want to pay for it.</p> <p>On 7/22/20 at 3:15 p.m. former Staff E (LPN) also confirmed the need for 1:1 supervision for Resident C-2 but said it was too much money.</p> <p>On 7/30/20 at 3:00 p.m. interview with Staff M who found Resident C-2 on the evening 1/23/20 stated if Resident C-2 would have had 1:1 supervision at the time she wouldn't have fallen that hard. Staff could have eased her to the floor or redirected her and called on the 2 way radios for assistance. Staff M reported Resident C-2's husband was often with her during the day but when he left, the resident was known to fall.</p> <p>FACILITY RESPONSE:</p>			
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