

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 9015		Date: October 13, 2020		
Facility Name: Mosaic – 102 Kelly's Court		Survey Dates: August 31, 2020 – September 3, 2020		
Facility Address/City/State/Zip 102 Kelly's Court Forest City, IA 50436				
		# 89722		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60	<p>481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and 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 provision 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>	I	\$3,250.00	Upon Receipt
W368	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p>			

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	<p>DESCRIPTION:</p> <p>Based on interviews and record review, the facility failed to ensure medications were consistently given in compliance with physician's orders. This affected 1 of 1 client identified during the investigation of #89772-C (Client #1). Finding follows:</p> <p>Record review on 9/02/20 revealed General Event Reports (GERS) dated 2/22/20 and 2/23/20, indicating Client #1 did not receive her medications on the morning of 2/22/20 due to no staff person showing up to pass morning medications and Client #1 refusing her morning medications on 2/23/20. The morning medications included medications for a seizure disorder. Client #1 had three documented seizures on 2/23/20 and went to the Emergency Room. Her family opted to take Client #1 to their family home for an extended visit in the late afternoon of 2/23/20.</p> <p>Client #1 was 33 years old with a diagnosis including moderate intellectual disability, epilepsy and recurrent seizures, intermittent</p>			
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	<p>explosive disorder and bipolar disorder. Client #1 was admitted to the facility on 10/15/19. According to the 30-day Individual Support Plan (ISP) completed 11/12/19, Client #1 had a history of seizures. The ISP noted Client #1's history of seizures was discovered after her admission to the facility and the facility had followed up with a neurology appointment. Client #1 had a program to request her medications at appropriate times. The program indicated Client #1 would set her alarm for 8:00 a.m., 12:00 p.m. and 8:00 p.m. to remind her it was time for her medication.</p> <p>A GER dated 2/22/20 noted the Program Manager was notified by staff at 9:49 a.m. that the medication passer had not shown up to pass morning medications. The Program Manager notified the on-call nurse. The on-call nurse determined the 8:00 a.m. medications could not be given due to the 2 hour window protocol (medications must be given within two hours of the scheduled time). According to the GER, staff were advised in the future to contact a supervisor within 15 minutes of the scheduled medication pass if</p>			

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	<p>the med passer did not show up. The GER indicated Client #1 did not receive her morning medications on 2/22/20, which included three seizure medications (Carbamazepine 600 mg, Clonazepam 0.5 mg and Lamotrigine 100 mg). Client #1's Medication Administration Record (MAR) was blank for 8:00 a.m. medications on 8/22/20. According to the MAR, Client #1 did receive her 7:00 p.m. medications on 2/22/20, which included the three seizure medications.</p> <p>A GER dated 2/23/20 noted Client #1 had been behavioral that morning and refused her morning medications. There was no documentation the facility nurse or a supervisor had been notified that Client #1 was refusing her medication. At approximately 9:30 a.m. Client #1 had a seizure, as evidenced by shaking, foaming at the mouth, and lips turning purple. The seizure lasted approximately 30 seconds and then Client #1 appeared to be in a deep sleep. Staff called 911, as well as the on-call nurse, Nurse Manager and the House Manager. The ambulance arrived and transported Client #1 to the emergency room.</p>			

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	<p>The agency also contact Client #1's parents regarding the incident. Staff documented on the GER they left the ER to bring Client #1 back to the facility at approximately 1:00 p.m. and Client #1 had another apparent seizure on the agency van about 10 minutes after leaving the hospital. The seizure lasted 10-15 seconds. Staff contacted the hospital regarding the seizure and was told Client #1 should be fine since she had received seizure medication at the ER. Client #1's MAR for the 8:00 a.m. medication on 2/23/20 indicated the medications had been refused.</p> <p>A second GER dated 2/23/20 noted Client #1's parents arrived in the afternoon to take her for a home visit. While the parents were present, Client #1 appeared to have another seizure at 4:20 p.m., lasting about two minutes. Staff notified the Nurse Manager and took vital signs. The Nurse Manager arrived to assess Client #1 and speak with Client #1's parents. Client #1 left with her parents at approximately 5:00 p.m. for an extended home visit.</p>			

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	When interviewed on 9/03/20 at 9:45 a.m. the Nurse Manager stated the on-call nurse who had worked on 2/22/20 and 2/23/20 had since passed away. The Nurse Manager said regarding the missed morning medications on 2/22/20, she would have either approved giving them late and/or tried to contact the physician, had she been the nurse notified of the situation. The Nurse Manager said Client #1 had been admitted to the facility in October 2019 and the family did not indicate a history of seizures. Client #1 wasn't taking seizure medication upon admission. Client #1 had seizure activity in November 2019 and the facility then discovered there was a history of seizures. Client #1 began taking seizure medication in November and there were no further seizures until the incidents on 2/23/20. The Nurse Manager acknowledged the on-call nurse should have attempted to contact the physician on 2/22/20 to see whether the 8:00 a.m. medications could be given late. The medication passer on the morning of 2/23/20 should have contacted the on-call nurse to inform her Client #1 was refusing to take her 8:00 a.m. medications.			

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	FACILITY RESPONSE:			
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