

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

Citation Number: 9039		Date: December 23, 2020		
Facility Name: Mediapolis Care Facility		Survey Dates: October 6 – October 26, 2020		
Facility Address/City/State/Zip 142 N. Orchard Mediapolis, IA 52637		91053-C		
LK				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

57.11	57.11(7) Orders for medications and treatments. Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III) Based on interview and record review, the facility failed to correctly administer medication for 1 of 6 current residents (Resident #4) and 3 of 4 former residents reviewed (Residents C2, C3 and C4). Findings follow: 1. Record review on 10/6/20 revealed Resident #4's July 2020 Medication Administration Record (MAR) indicated she was to take Linzess 290 mcg. once daily. Handwritten on the July MAR was the word HOLD on the dates of July 8, 9, 11, 12 and 13. HOLD was also written on the dates of July 9, 10, 11, 12, 13, 14, 15 and 18 for the medication Polyethylene Glycol, 17 grams/8oz. once daily. Resident #4 was to take Senna 17.2 mg. daily but HOLD was written on the dates of July 9, 10, 11, 12, 13 and 18. There was no corresponding order from Resident #4's physician noting these medications should have been held on these dates. 2. Resident C2 was admitted to the facility on 2/28/20. According to his admission orders dated 2/26/20, he was to take the following medications:	I	\$4,500.00	Upon Receipt
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Facility Administrator

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	Fluoxetine, 60mg. one pill daily; Mirtazepine, 7.5mg. one pill at night; Hydroxyzine HCL, 50mg. three times a day; and Librium, 25 mg. four times a day. When Resident C2 arrived at the facility, his February and March 2020 MARs noted he was to take Mirtazepine, 15mg. at bedtime rather than 7.5 mg. The MARs also indicated his Hydroxyzine was to be taken as needed, when the order said three times daily. Librium was not listed on either MAR. Resident C2 received new orders from his primary care provider on 3/27/20 changing his Mirtazepine to 15mg. at bedtime as needed. A Vitamin B complex vitamin was added to his medication list. No changes were made to his other medications. The Vitamin B complex vitamin was never added to Resident C2's MAR and therefore never administered to him. 3. Resident C3 was admitted to the facility on 2/21/20 at 3:30 PM. His February 2020 MAR indicated he was to take the medication Clozapine, 150mg. in the morning and 200mg. at night. Clozapine is an antipsychotic medicine according to Drugs.com which works by changing the actions of chemicals in the brain. Clozapine is used to treat schizophrenia after other treatments have failed. Clozapine is also used to reduce the risk of suicidal behavior in people with			
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	schizophrenia or similar disorders. According to the February 2020 MAR, Resident C3 did not receive his morning dose of Clozapine on February 22 or 23. The MAR was blank with no reason given for not administering the medication on these days. A review of the March 2020 MAR revealed Resident C3 did not receive his morning dose of Clozapine on March 1, 2, 3, 5, 6, 19, 20, 25 and 26. He missed his evening dose of Clozapine on March 1, 2, 3, 5, 6, 13, 19, 25 and 26. All days but the morning dose of the 19th were marked as the pill being unavailable. The May 2020 MAR notated Resident C3 did not receive his morning dose of Clozapine on May 1, 2, 3, 4, 7, 12 or 13. Resident C3 missed his evening dose of Clozapine on May 1-14. Nurse's notes revealed on 5/4/20, Resident C3 shouted gibberish, refused to attend groups and stormed out of rooms. On 5/5/20, he was defiant and refused to partake in lab draws, however later in the day Owner/Director 2 was able to get Resident C3 to get his lab draws. Per the results of the lab draw his medication should have been restarted. On 5/11/20, Resident C3 yelled at multiple staff, screamed and threw punches in the air. The DON (Director of Nursing) noted she was trying to get Resident C3 an appointment with a psychiatric provider as his had recently resigned. She maintained his weekly labs in order to keep			
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	getting his Clozapine. Resident C3 was noted to be delusional and confused all evening on 5/19/20. On 5/20/20, Resident C3 urinated on his window sill and slapped the Administrator in the face. He became combative and 911 was called. He was transferred to the hospital and later discharged from the facility. 4. Record review revealed Resident C4's January 2020 MAR indicated he was to take 300mg. of Clozapine at bedtime. He did not receive this medication from January 11-19. A review of the February 2020 MAR showed Resident C4 did not receive Clozapine from February 1-18. He did not receive the medication on April 18-20 according to the MAR. 5. An interview was conducted with the nurse at the office of the psychiatric provider for Residents #4 and C4 on 10/15/20 at 8:10 AM. She reported all medication refills and lab requests received for these residents were processed within one day. 6. The pharmacy for the residents was also contacted as they assisted the facility with filling the Clozapine for the residents once required lab work was completed. The pharmacist reported facility staff was to take a resident for labs 2-5 days before their Clozapine ran out, then notify the pharmacy the labs had been drawn. Resident			
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	C3 was entered into the pharmacy's system on 3/3/20 and an emergency supply of Clozapine was sent to the facility that same day. The pharmacy received the results of the lab work on 3/6/20. The facility did not take Resident C3 for his lab work in May until 5/5/20. The pharmacy delivered Clozapine to the facility for Resident C3 on 5/5/20, although according to the MAR it was not administered to the resident. The pharmacist reported they only sent out a 19 day supply of medication to Resident C4 on 12/23/19. She did not know why a 28 day supply of medication was not sent out, but speculated it was all the medication the pharmacy had on hand. The facility did not contact the pharmacy for additional medication until 1/20/20 and the pharmacy then sent out 9 more pills at that time. Resident C4 did not have his lab work completed for his Clozapine until 2/19/20 enabling him to get his refill for the 2/1-18/20 period. The pharmacy sent Clozapine to the facility on 2/19/20. His lab work was completed on 4/21/20 which accounted for the missing medication on 4/18-20/20 as the pharmacy sent out a refill on 4/21/20. 7. The Administrator, DON and Program Director were interviewed about medications on 10/13/20 at 2:25 PM. The DON reported an RN had the ability to hold medications and the nursing			
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	judgement to hold Resident #4's meds in July was appropriate. The facility contacted Resident #4's ARNP on 10/13/20 and she reportedly said it had been appropriate for the nurse to hold Resident #4's medication in July 2020. They reported Residents C3 and C4 saw the same mental health practitioner who did not fill medication refills and lab order requests promptly which led to residents going for periods of time without Clozapine. They also stated the pharmacy did not deliver the Clozapine according to the delivery sheets.			
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50.7	481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. Based on interview and record review, the facility failed to notify the Department of elopements regarding 2 of 5 residents reviewed (Residents #4 and #5). Findings follow: 1. Review of Nurse's Notes on 10/8/20 revealed Resident #4 left the facility after supper on 4/7/20 for approximately one and a half hours. Staff A drove around looking for Resident #4 and finally found her sitting on a bench by the highway. Resident #4 was brought back to the facility. Staff A talked with Resident #4 and the resident's mother over the phone. Items were removed from Resident #4's room after she lashed out due to	II	\$500.00	Upon Receipt
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	reporting being suicidal. She later calmed down and fell asleep. A Nurse's Note dated 6/22/20 identified Resident #4 wrote "Die" on her bilateral arms. Medication was given to Resident #4 and she was placed on suicide watch. Later in the afternoon, she eloped but was found and returned by staff without anyone needing to call the sheriff. 2. A review of Nurse's Notes for Resident #5 revealed on 4/30/20, she left the facility around 4:45 PM. Staff went looking for her and could not find her anywhere. The police were called and she was found and brought back to the facility at 6:30 PM. She took a shower, had a snack and went to bed. There was no sign she suffered any injury. A Nurse's Note documented on 5/22/20, Resident #5 took off around 5:45 PM. She was found on the side of the highway running towards a van which was pulled over on the side of the road. Resident #5 was brought back to the facility around 6:30 PM. According to a Nurse's Note, Resident #5 left the facility at 1:30 PM on 5/29/20. The police were called and a missing person's report was			
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	completed. Resident #5 arrived back at the facility around 5:30 PM. The Administrator and Director of Nursing talked with Resident #5 about the incident. An Incident Report was completed giving more information and describing the situation as an elopement. Resident #5 had been playing basketball on the patio and walked away from the facility. The Administrator signed the incident report. A Nurse's Note dated 6/19/20 reported Resident #5 eloped that day. A missing person's report was filed. Resident #5 was found by staff and the report was canceled. A Comprehensive Overview dated 6/25/20 noted she was found walking out in a field on the south end of town. On 8/28/20 a Nurse's Note documented Resident #5 eloped from the facility after dinner. Resident #5 eloped from the facility on 9/13/20 according to Nurse's Notes and was brought home by administration. 3. Staff A was interviewed on 10/13/20 and reported Resident #4's mother called on 4/7/20 to notify them her daughter had left the facility. Staff A had a difficult time locating Resident #4 in the community. Staff A said she worked on an "as needed" basis, but recalled two times Resident #4			
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	eloped from the facility. She said staff tried to keep a close eye on Resident #5. She recalled one time when Resident #5 eloped and the Sheriff had to be contacted. When interviewed on 10/13/20 at 12:45 PM Staff B recalled one incident when she was working when Resident #4 eloped. Although oftentimes she was aware when Resident #4 left the building on her own, there was one time in late July or early August when she did not know Resident #4 left. She was later found sitting on a bench away from the property. Staff B described Resident #5 as someone who took off like a ghost. The last time this happened was at the end of August when Resident #5 was not in her bed when they did bed checks. Another staff member's family found Resident #5 walking down the road. Staff B believed Resident #5 had eloped 3 or 4 times times when she was working at the facility. On 10/13/20 at 1:40 PM, the Program Director reported she could think of 2 or 3 times when Resident #5 had eloped from the facility, stating she liked to go out through the window. Resident #4's mother was contacted on 10/12/20 at 2:40 PM. She stated she had called her daughter on 4/7/20 and her daughter said she was lost. The mother called the facility and			
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	informed them her daughter had left and where she was. Someone from the facility reportedly called her back an hour later and said they couldn't find her daughter. The mother then gave them directions again and her daughter was located. A meeting was held with the Administrator, Director of Nursing and Program Director on 10/13/20 at 2:25 PM. They stated they did recall the incident of Resident #4's mother calling to report her daughter missing, but generally when Resident #4 left, she made a big production of leaving. They could not recall other times she had left without staff being aware of her leaving. The Administrator thought reports had been made when Resident #5 had eloped from the facility, but the Program Director confirmed they had not.			
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