

**Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation**

Date: July 24, 2019
Program Name: Edencrest at Siena Hills
Address: 455 SW Ankeny Rd Ankeny, IA 50021
Type of Action: Investigation #83095-C & Revisit of Investigation #79828-C
Date(s) of Action: 6/4/19 – 6/11/19

State Rule #	State Rule	Amount of Civil Penalty
67.13(4)	<p>481-67.13(17A,231C,85GA,SF394) Exit interview, final report, plan of correction.</p> <p>67.13(4) Monitoring revisit. The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.</p> <p>Based on interview and record review the Program failed to implement the plan of correction dated 12/12/18. Finding follows:</p> <p>Record review revealed a regulatory insufficiency was cited at 67.5(6)d on 12/11/18. The Program submitted a plan of correction indicating corrective action would be implemented effective 12/12/18.</p> <p>A review of the Plan of Correction indicated all aspects of the plan were not implemented or completed by the effective date of 12/12/18 for medications administered per physician's orders.</p> <p>During the revisit a regulatory insufficiency was written at 67.5(6)d regarding a tenant not receiving medication as order by the physician.</p>	\$3500.00
67.5(6)d	<p>481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following:</p> <p>67.5(6) When medications are administered traditionally by the program:</p> <p>d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</p> <p>Based on interview and record review the Program failed to consistently ensure medications were administered as prescribed. This affected 1 of 2 tenants reviewed who received insulin injections (Tenant #1). Finding follows:</p> <p>Record review revealed Tenant #1 had diagnoses including: Type 2 diabetes mellitus without complications. Physician's orders for Tenant #1 dated 4/10/19 included Levermir INJ Flextouch inject 15 unit</p>	

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	<p>subcutaneously at bedtime for diabetes, Novolog INJ Flexpen inject 6 unit subcutaneously two times a day for diabetes, and Accu-Check Aviva Test one strip two times a day every Monday, Wednesday, and Friday for blood sugar.</p> <p>Record review on 6/6/19 revealed a Health Status note dated 5/14/19 read: "RN called HyVee pharmacy again this am as resident's needles did not come again last evening as pharmacist had said they would." Further review of the note revealed the following statement, "RN stated that she will call resident's daughter to pick up medication today as it has been a week now that the resident has not had insulin as RN called last week on 5/6/19 and sent order with the latest insuling doses and how often."</p> <p>Further review of Progress Notes on 6/10/19 revealed the following notations:</p> <ul style="list-style-type: none">a. 5/5/19 at 10:08 a.m. Novolog INJ Flexpen - Inject six units subcutaneously two a day for diabetes related to Type 2 diabetes mellitus without complications - "She is out of needles."b. 5/5/19 at 10:27 P.M. Levemir INJ Flextouch -Inject 15 unit subcutaneously at bedtime for diabetes. "Out of needles. Alerted the family."c. 5/12/19 at 10:12 a.m. Novolog INJ Flexpen- Inject 6 units subcutaneously two times a day for diabetes related to Type 2 diabetes mellitus without complications - "Out of needles."d. 5/13/19 at 4:41 p.m. Novolog INJ Flexpen - Inject six unit subcutaneously two times a day for diabetes related to Type 2 mellitus without complications - "No needles."e. 5/13/19 at 10:14 p.m. Levemir INJ Flextouch - Inject 15 unit subcutaneously a bedtime for diabetes -"No needles." <p>Continued record review revealed Tenant #1's blood sugar readings were as follows:</p> <ul style="list-style-type: none">a. 5/3/19 9:30 a.m. 167 and 4:30 p.m. refusedb. 5/6/19 9:30 a.m. 252 and 4:30 p.m. 238c. 5/8/19 9:30 a.m. 185 and 4:30 p.m. 173d. 5/10/19 9:30 a.m. 160 and 4:30 p.m. 121e. 5/13/19 9:30 a.m. refused and 4:30 p.m. 343f. 5/15/19 9:30 a.m. 157 and 4:30 p.m. 213 <p>When interviewed on 6/4/19 at 11:40 a.m. Staff A said in the past supplies for insulin have not been available. She said it had been better lately. Staff A said the Program had a box of insulin supplies staff can use if tenants do not have the needed supplies, such as needles for insulin pens.</p> <p>When interviewed on 6/6/19 at 8:55 a.m. the Director of Clinical Quality Management confirmed the Program was responsible to administer Tenant #1's medication but failed to do so when needed supplies (needles) were not available.</p>	
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