

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

<b>Date:</b> October 31, 2018
<b>Program Name:</b> Elmwood PE, LLC
<b>Address:</b> 190 N 15 <sup>th</sup> Street Onawa, IA 51040
<b>Type of Action:</b> Investigation #78314-I, 77752-C, 77845-C
<b>Date(s) of Action:</b> 9/24/18 – 10/3/18

State Rule #	State Rule	Amount of Civil Penalty
67.5(6)d	<p><b>481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following:</b></p> <p style="padding-left: 40px;"><b>67.5(6) When medications are administered traditionally by the program:</b></p> <p style="padding-left: 80px;"><b>d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</b></p> <p>Based on interview and record review the Program failed to administer medications as prescribed by the tenant physician. This affected 1 of 1 tenants reviewed with chronic urinary tract infections (UTIs) (Tenant #1). Finding follows:</p> <p>1. Record review revealed discharge instructions, dated 7-23-18, revealed Tenant #1 was admitted to the hospital on 7-11-18 due to unresponsiveness and fever. Tenant #1 was diagnosed with UTI and sepsis. Nurses notes included in the instructions included: "...Her condition was very guarded with episodes of agonal breathing and being in and out of responsiveness. Both Blood Cultures (times two) and urine culture were positive for ESB: (extended spectrum B lactamase). She was treated with aggressive IV (intravenous) fluids and IV antibiotics... Her (white blood cell) had ranged from 9.4 - 12.5. Platelet count was also low but as now come up to 159..." and noted she was a high readmission risk.</p> <p>Continued review of Tenant #1's file revealed the following:</p> <p>a. Tenant #1's service plan, dated 9-7-18, revealed her to be high risk for repeat UTIs. The service plan indicated Tenant #1 required assistance with medication administration and noted the nurse would review medications quarterly and staff would assist the tenant to remove medications from lockbox, administer and document.</p> <p>b. a physician's order sheet and progress notes revealed tenant #1 prescribed Citrucel and Bactrim DS on 6-30-18.</p> <p>c. A History and Physical Report, faxed to the Program on 9-27-18, revealed Tenant #1 visited her primary physician on 7-5-18 with complaints of constipation and chronic pain. She was prescribed</p>	<b>\$2000.00</b>

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

Miralax daily for constipation and Duragesic patch for chronic pain with Hydrocodone changed from three times a day to every 6 hours as needed (PRN). Further review revealed the physician phoned the Program with the new orders.

d. A History and Physical Report, faxed to the Program on 9-27-18, revealed Tenant #1 saw her primary physician on 7-10-18 with concerns of overuse of medications. The Duragesic patch was discontinued and Hydrocodone continued to be administered.

A review of Tenant #1's Medication Administration Records (MAR) for June and July of 2018 revealed the Program failed to update to reflect the new medication orders on 6-30-18. Tenant #1 received Hydrocodone 5/325 mg three times daily and received two doses on 7-7-18, 3 doses on 7-8-18, and 3 doses on 7-9-18. The Fentanyl patch was applied on 7-7-18. The Program failed to administer medications as ordered, including Batrim DS.

When interviewed on 9-26-18 at 6:51 p.m. Staff C stated in early July she and a nurse looked for Tenant #1's Fentanyl patch and found a prescription bottle of an antibiotic for Tenant #1 that contained 6 pills. She stated the MAR did not include the medication to be administered. A few days later, Tenant #1 went to the hospital and was diagnosed with sepsis. She stated the nurse called the Director of Nursing about the Fentanyl patch and he was instructed not to apply it until the Program received the doctor's order. She stated medications were being delivered without physician's orders, so they were being put on the MAR until 1-2 days later.

During an interview on 9-25-18 at 3:28 p.m. the Pharmacist confirmed the Bactrim was delivered to the Program on 6-30-18 and signed as received by Staff A. He stated cassettes are delivered weekly and start on each Friday. There would have been seven doses sent to get them through to the next Friday. He stated the last three days were included in the new cassettes since it was a ten day course of medication.

When interviewed on 9-25-18 at 2:02 p.m. Staff A stated she received a prescription for an antibiotic from the pharmacy for Tenant #1 and believed it was on a Saturday. She stated she called the Executive Director and received permission to administer the medication. She stated she did not document on the MAR as administered and left a note along with the medication for the other staff to know it was to be given. She stated she did not follow up the next time she worked.

When interviewed on 9-26-18 at 2:20 p.m. Staff D stated when medications were delivered the nurses did not add them to the MAR without the doctor's order so the tenant went without the medication until the order was received and added to the MAR. She stated she was informed by Staff A Tenant #1 had a new antibiotic and was told the Executive Director would take care of it on Monday.

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

During an interview on 9-26-18 at 10:50 a.m. Staff E stated she did not remember administering an antibiotic from a bottle for Tenant #1. She does not recall administering a powder laxative and stated Tenant #1 does have some Miralax in her room but has not seen her take any. She stated the nurses have told her they will not add a medication to the MAR without the doctor's order. She stated the when Tenant #1 started the Fentanyl patch she continued to receive the Hydrocodone as scheduled and a few days later she was found unresponsive when Staff E went to her room. Staff E stated 911 was called and she was taken to the hospital.

During multiple interviews on 9-26-18 and 9-27-18 the Executive Director confirmed these findings. She stated communication was poor with the Director of Nursing as to who was responsible to add medications to the MAR. She stated tenants went to the doctor and did not provide the Program with current orders for medications so she did not know of medication changes until they were delivered from the pharmacy. Only then were they added to the MAR. She stated she was aware of the Fentanyl patch order on 7-5-18 and called the doctor to clarify if the the Hydrocodone was to be PRN or continued as scheduled. She said she did not hear back and did not follow up and on 7-9-18 a nurse contacted the doctor and the Hydrocodone was to be PRN.

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

--	--	--