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

Date: July 23, 2019
Program Name: Country Manor
Address: 900 W 46th Street Davenport, IA 52806
Type of Action: Investigations # 83177-C, 83178-C, 83183-C, 83192-C, 83926-C
Date(s) of Action: 6/10 – 6/19/19

State Rule #	State Rule	Amount of Civil Penalty
67.5(6)d	**481-67.5(231B,231C, 231D) Medications. Each program shall follow its own written medication policy, which shall include the following:** **67.5(6) When medications are administered traditionally by the program:** **d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.** Based on interview and record review the Program failed to administer medications as ordered for 4 of 5 tenants reviewed who received medications administered by staff (Tenants #1, #3, #4 and #6). Findings follow: 1. On 6-11-19 at approximately 2:15 p.m. Tenant #1 was observed to be restless while sitting in the lift recliner in the living area on side B. Staff F was seated next to Tenant #1 and provided one to one assistance. When Tenant #1 attempted to get up, Staff F told him he needed to stay seated and appeared to lightly touch his leg as she encouraged him to stay seated. The recliner foot pedal was in the upright position. When interviewed on 6-11-19 at approximately 2:20 p.m. the Management Company Nurse revealed Tenant #1 was experiencing increased restlessness. Hospice was notified and was coming to assess Tenant #1. When interviewed on 6-11-19 at 4:20 p.m. Hospice Nurse #1 stated her visit to Tenant #1 was for increased agitation. Lorazepam/Ativan had been ordered for the tenant on 5-8-19 but he was currently out of the medication as the script was not refilled as needed. Review of Tenant #1's May and June 2019 medication administration records (MARs) and Progress Notes (administration notes from 5-1-19 to 6-10-19) revealed the scheduled Lorazepam/Ativan (3 times a day) was documented as not available to administer 23 times between 5-10-19 at 1:00 p.m. and 5-31-19 at 8:00 p.m. and 30 times from 6-1-19 at 8:00 a.m. to 6-11-19 at 1:00 p.m. The medication was documented as not available to administer on 5-16-19 however was documented as given the day prior and the day after. In addition, the order was for a 14 day supply, however the MAR documented the medication was	$4000.00

	administered several times past the end date of the 14 days (5-22-19). Although the script had not been refilled after the original 14 day supply should have been exhausted, the med was documented as given on 6-10-19 at 8:00 a.m. despite the lack of availability per documentation 26 times before 6-10-19 and 4 times after it was documented as given. It was also documented refused on 6-7-19 at 8:00 a.m. despite prior and subsequent unavailability of the medication. The May MAR also reflected an order for Seroquel tablet 25 mg, three times per day and an order for Venlafaxine HCL 75 mg twice per day. The Seroquel was not available to administer 25 times in May and the Venlafaxine was not available to administer 3 times in May. An incident report dated 6-11-19 indicated the scheduled Lorazepam/Ativan was not available for administration. Pharmacy had been contacted and reported the script for Ativan had not been refilled after the 14 day supply was finished. When interviewed on 6-13-19 at 1:58 p.m. the Manager revealed she had contacted pharmacy on 5-31-19 regarding Tenant #1's Lorazepam/Ativan once she was alerted by staff. Pharmacy did not have a script for Lorazepam/Ativan (tablets) and said they would contact hospice. There was a script available for liquid Lorazepam/Ativan. Nurse Clinician #1 followed up with hospice and the scheduled liquid dose of Lorazepam/Ativan was received on 6-12-19. According to the Manager, it was the responsibility of the Program's nurse to reorder the Lorazepam/Ativan once the 14 day supply was nearing the end. In summary, Tenant #1 was observed on 6-11-19 and appeared restless. Hospice was contacted to visit and it was determined there was an issue with the orders for Lorazepam/Ativan and availability of the medication to administer. May and June 2019 MARs reflected over 50 times it documented as not available to administer. Tenant #1 also had Seroquel and Venlafaxine that were noted as not available to administer. 2. Tenant #3's May and June 2019 MARs reflected an order for Flaxseed Oil 1200 mg twice daily. The May MAR and Progress Notes (administration notes from 5-1-19 to 6-11-19) reflected the medication was unavailable to administer 36 times from 5-2-19 at 8:00 a.m. until the end of the month. Despite being documented as unavailable to administer at times during the month of May there were 24 times staff documented it was given including on 5-17-19, 5-18-19, 5-19-19 and 5-20-19. On those days the medication was documented as administered at 8:00 a.m. but not available to administer at 4:00 p.m. Tenant #3's June MAR and Progress Notes (administration notes from 5-1-19 to 6-11-19) reflected the Flaxseed Oil was not available to administer 16 times from 6-1-19 at 4:00 p.m. to 6-11-19 at 4:00 p.m. Despite being documented as unavailable during the majority of that time period, there were 6 times staff documented the medication was given.	

	3. Tenant #4's May and June 2019 MARs revealed orders for Linzess 290 micrograms (mcg) once daily. The MARs and Progress Notes (administration notes from 5-1-19 to 6-12-19) reflected the medication was unavailable to administer 9 times from 5-2-19 to 5-27-19 and 5 times from 6-4-19 to 6-9-19. The May MAR also reflected an order for Sulfamethoxazole-Trimethoprim to be given twice daily for seven days for a urinary tract infection. The medication was documented as not given on 5-17-19, 5-19-19 and 5-20-19 at 8:00 p.m. It was documented as needing to be re-ordered on 5-17-19 and 5-19-19. 4. Review of Tenant #6's file revealed she received hospice services. When interviewed on 6-13-19 at 1:15 p.m. Hospice Nurse #2 revealed Tenant #6's seizure medication (Keppra) previously ran out, she was without it for two days and on the third day she had a seizure. The medication had not been re-filled. Hospice Interdisciplinary Team Notes dated 5-23-19 reflected staff reported possible "seizure activity" that morning. Tenant #6 had returned to her baseline when the nurse arrived. The seizure medication was to be re-filled and staff were instructed to give Lorazepam until seizure medication arrived. Review of the Interdisciplinary Team Notes did not indicate any prior seizure activity or subsequent seizure activity after the medication was re-filled and administered per order. Tenant #6's May 2019 MAR revealed orders for Levetiracetam Solution 100 mg/milliliters (ml), 5 ml to be given daily at 8:00 a.m. as an anticonvulsant; Ensure nutritional supplement three times a day and Acetaminophen 500 mg four times a day for pain. The May MAR and Progress Notes (administration notes from 5-1-19 to 6-13-19) revealed the Levetiracetam Solution was unavailable to administer on 5-16-19, 5-21-19, 5-22-19 and 5-23-19, the Ensure was not available to administer on 5-2-19 at 11:30 a.m. and the Acetaminophen was not given 7 times during the month. In summary, Tenant #6's medications were not given as ordered including an anticonvulsant. During the time the anticonvulsant was not administered the tenant experienced possible seizure activity. 5. The Program's policy and procedure for medications indicated the nurse would review MARs two to three times weekly until an "acceptable process of med administration is consistent." After it was in place the nurse would review MARs monthly. All staff who administered medication were required to complete a check of the electronic MARs and narcotic counts at the end of the shift with another staff. All discrepancies would be addressed immediately. Ordering of new medications and refills "will be the sole responsibility of the nurse, lead resident assistant or delegate via nurse discretion." The Program had been without a Healthcare Coordinator since 5-28-19.	