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

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| **Date:** August 11, 2020 |
| **Program Name**: Country Manor Memory Care |
| **Address:** 900 W 46th St Davenport IA 52806 |
| **Type of Action:** Complaint #91827-C |
| **Date(s) of Action**: 7/7/20 – 7/14/20 |

| State Rule # | State Rule | Amount of Civil Penalty |
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| **67.3(2)** | **481-67.3 Tenant rights.** All tenants have the following rights:<br>67.3(2) To receive care, treatment and services which are adequate and appropriate.<br><br>Based on interview and record review the Program failed to ensure care, treatment and services were adequate and appropriate for 1 of 3 tenants reviewed (Tenant #1). Findings follow:<br><br>Record review on 7/7/20 revealed two medication error reports dated 7/1/20. According to the reports Staff A assisted Tenant #1 administer 12 units of Novolog before breakfast at 8:00 a.m. when the tenant's blood sugar was 63. At 10:40 a.m. Staff A administered 8 units of Lispro. The report stated Tenant #1's blood sugar was 40. According to the medication error reports tenant was incoherent and Emergency Medical Services was called.<br><br>Record review on 7/7/20 revealed a progress note for 7/1/20 written by Registered Nurse (RN) A. RN A had responded to a staff report of Tenant #1 crying and verbalizing pain. RN A assessed Tenant #1 and instructed staff to get juice and candy. She checked Tenant #1's blood sugar with a result of 39 and attempted to get him to drink orange juice and eat chocolate with no success. RN A instructed staff to call 911 and she rechecked Tenant #1's blood sugar, which was 29. When Emergency Medical Services (EMS) arrived the tenant's blood sugar was 21. EMS administered dextrose intravenously and rechecked blood sugars with a result of 167. Tenant #1 regained consciousness, ate lunch and resumed normal activities.<br><br>Review of Tenant #1's record revealed an admission date of 6/4/20. The tenant had orders dated 6/5/20 for a consistent carbohydrate diet (approximately 60 carbs per meal) and 12 units of Novolog before breakfast, 8 units before lunch and 20 units before dinner.<br><br>When interviewed on 7/7/20 at 11:55 a.m. RN A said Staff A should not have given the insulin based on the blood sugar results. At both administration times (8:00 a.m. and 10:40 a.m.) Tenant #1's blood sugar level was low. She had since retrained the staff and added information to Tenant #1's service plan. RN A explained she completed Tenant #1's 30 day assessment and service plan on the | **$3500.00** |

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| | day after the incident and included directions for staff to hold the insulin if his blood sugar reading was below 80 and to call the nurse.<br><br>Record review on 7/13/20 revealed a service plan dated 6/4/20. The service plan included a directive for staff to remind Tenant #1 to go to meals. The service plan indicated the tenant preferred medications to be affective and administered as ordered. On 7/7/20 RN A confirmed the service plan dated 6/4/20 was in effect when the incident occurred. | |
| **67.9(4)c** | **481-67.9(231B,231C,231D) Staffing.**<br>67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:<br>c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.<br><br>Based on interview and record review the Program's registered nurse (RN) failed to ensure uncertified staff were trained to meet the needs of 1 of 1 tenants reviewed with diabetes (Tenant #1). Finding follows:<br><br>Record review on 7/7/20 revealed two medication error reports dated 7/1/20. According to the reports Staff A assisted Tenant #1 administer 12 units of Novolog before breakfast at 8:00 a.m. when the tenant's blood sugar was 63. At 10:40 a.m. Staff A administered 8 units of Lispro. The report stated Tenant #1's blood sugar was 40. According to the medication error reports tenant was incoherent and Emergency Medical Services was called.<br><br>Record review on 7/7/20 revealed a progress note for 7/1/20 written by Registered Nurse (RN) A. RN A had responded to a staff report of Tenant #1 crying and verbalizing pain. RN A assessed Tenant #1 and instructed staff to get juice and candy. She checked Tenant #1's blood sugar with a result of 39 and attempted to get him to drink orange juice and eat chocolate with no success. RN A instructed staff to call 911 and she rechecked Tenant #1's blood sugar, which was 29. When Emergency Medical Services (EMS) arrived the tenant's blood sugar was 21. EMS administered dextrose intravenously and rechecked blood sugars with a result of 167. Tenant #1 regained consciousness, ate lunch and resumed normal activities.<br><br>Review of Tenant #1's record revealed an admission date of 6/4/20. The tenant had orders dated 6/5/20 for a consistent carbohydrate diet (approximately 60 carbs per meal) and 12 units of Novolog before breakfast, 8 units before lunch and 20 units before dinner. | |

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| | Record review on 7/8/20 revealed Staff A receiving nursing delegation on 4/8/20 regarding Insulin Administration and Insulin Injection Assistance.<br><br>When interviewed on 7/7/20 at 11:55 a.m. RN A said Staff A should not have given the insulin based on the blood sugar results. At both administration times Tenant #1's blood sugar level was low. RN A admitted Staff A's training had not included monitoring readings for low blood sugar levels. | |