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

Date: January 6, 2019
Program Name: Prairie Hills at Des Moines Memory Care
Address: 5815 SE 27th Street Des Moines, IA 50320
Type of Action: Incident #86752, Complaint #86607
Date(s) of Action: 12/3/19 – 12/6/19

State Rule #	State Rule	Amount of Civil Penalty
67.19(3)	Based on interview and record review the Program failed to ensure staff administered medications to the correct individual as prescribed for 1 of 1 tenants reviewed regarding Incident 86752 (Tenant #1). Findings follow: Record review on 12-3-19 of Tenant #1's Medication/Treatment Error Report dated 10-15-19 revealed Staff B administered the wrong medications to Tenant #1. Tenant #1 required emergency care due to a drop in blood pressure and unresponsiveness. During an interview on 12-4-19 at 10:11 a.m. Staff B stated she had medications ready for another tenant in a medicine (med) cup and needed to get a drink for him to take them. She stated Tenant #1 stopped to talk to her, she became distracted and handed Tenant #1 the medication cup. She observed Tenant #1 swallow the medications. Staff B admitted she failed to follow the six rights of medication administration as trained and allowed Tenant #1 to ingest another tenant's medications. She stated she immediately contacted the on-call nurse and was instructed to call 911. She monitored Tenant #1's vitals until the ambulance arrived and noted her blood pressure dropped during this time. She stated Tenant #1 became sleepy and Emergency Medical Service (EMS) arrived and took over care of the tenant. Staff A confirmed Tenant #1 received the following medications that were not prescribed to her: Acetaminophen 500 milligrams (mg), aspirin 325 mg, Buspirone 10 mg, carb/levo 25-100 mg, Escitalopram 20 mg, furosemide 40 mg, Lisinopril 10 mg, lorazepam 1 mg, Meloxicam 7.5 mg, quetiapine 100 mg, and Thera-M multi-vitamin tablet. Review on 12-4-19 of a 24 hour watch document regarding the incident revealed Tenant #1's blood pressure at 8:00 a.m. was 140/70 and dropped to 97/63 at 8:31 a.m. Further review revealed EMS arrived at 8:55 a.m. and Tenant #1 was taken to the hospital. Review of Charting Notes on 12-4-19 revealed an entry dated 10-17-19 documenting Tenant #1 received the wrong medications on 10-15-19 resulting in low blood pressure. She was transported to the hospital for evaluation and admitted with a diagnosis of toxic encephalopathy. She returned to the Program on 10-17-19 after the toxic encephalopathy had resolved.	$1000.00

	On 12-5-19 review of a hospital records for 10-15-19 noted a diagnoses of acute encephalopathy and accidental medication error. The tenant was noted to be in fair condition. The physician recommended admission to the hospital for further evaluation including cardiac monitoring and to ensure improvement of encephalopathy. During an interview on 12-5-19 at 3:38 p.m. the Executive Director confirmed these findings. The Program followed up with disciplinary action and further training.	