

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

Date:	January 15, 2019
Program Name:	Edencrest at Siena Hills
Address:	455 SW Ankeny Rd Ankeny, IA 50023
Type of Action:	Investigation #79828-C
Date(s) of Action:	12/11/18 – 1/11/19

State Rule #	State Rule	Amount of Civil Penalty
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 style="padding-left: 40px;">67.5(6) When medications are administered traditionally by the program:</p> <p style="padding-left: 80px;">d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</p> <p>Based on staff interviews and record reviews, the Program failed to administer tenants' medications as prescribed by a physician. This affected 1 of 3 tenants reviewed during the investigation of #79828-C.</p> <p>Finding follows:</p> <p>Record review on 12/11/18 revealed a program medication error record, dated 9/3/18, documented staff went to administer morning medications to Tenant #1 on 9/3/18 and found another tenant's medications in her medication cabinet, including two bubble packs containing Vitamin D3 and Donepezil (Aricept). The medications were not prescribed to Tenant #1. The bubble packs were opened on 8/31/18. The Nurse was notified and the Nurse notified the family and physician of the error. The report further noted Tenant #1 was sent to the ER on Friday, 8/31/18 with complaints of nausea, vomiting, diarrhea, elevated BP and a sweaty/clammy feeling. The report noted no injuries observed post incident. Further review of the record documented, "medications were placed in the wrong resident's apartment and were administered to the wrong resident." A Program Progress note, dated 9/4/18, documented an order received to push fluids and Ondansetron (anti-nausea/vomiting medication) was ordered as needed for nausea.</p> <p>Further record review on 12/11/18 revealed a Counseling Documentation Form, dated 9/5/18, for Staff B, noted on 8/31/18, 9/1/18 and 9/2/18 staff administered two incorrect medications to Tenant #1. The form noted, "This caused the resident to become very ill." The form stated the action was a written warning and the nature of the violation was a policy or safety violation.</p> <p>According to the Medication Administration policy, staff should go to resident's apartment, unlock cabinet and administer appropriate</p>	\$1500.00

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	<p>medications. Once meds were administered staff should sign the MAR prior to locking cabinet again.</p> <p>When interviewed on 12/11/18, the Healthcare Coordinator (HC) confirmed Tenant #1 received the wrong medications on 8/31/18, 9/1/18 and 9/2/18. She added the wrong bubble packs were placed in Tenant #1's cabinet. She noted the Tenant went to the ER for nausea on 8/31/18. The tenant was prescribed Ondansetron and returned to the Program after "an hour or so." The HC added the nausea may or may not have been related to Tenant #1 receiving the wrong medications. The HC stated she was not sure how staff member B could have made the medication error, as all medications administered by staff were done electronically. During additional interview on 12/11/18, the HC described how Tenants' medications were delivered from the pharmacy. She noted the evening staff responsible for medications checked in the medications and placed the medications in the tenants' apartment cabinets. When asked if there was a program policy regarding medication delivery from the pharmacy, the HC reported there was no policy, but the program was in the process of creating a policy for medication delivery from pharmacy. The HC also reported the Program no longer administered the Tenant's medications, as the family had currently taken over that responsibility.</p>	
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