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

Date:	April 16, 2018
Program Name:	Traditions at West Union
Address:	609 Hwy 150 N
Type of Action:	investigation
Date(s) of Action:	3/22/18, 3/26/18, 4/9/18

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	**481—67.3(231B,231C,231D) Tenant rights.** All tenants have the following rights: **67.3(2)** To receive care, treatment and services which are adequate and appropriate. Based on interview and record review the Program failed to ensure care, treatment and services were adequate and appropriate for 1 of 2 former tenants reviewed (Tenant #2). Findings follow: 1. Review of Tenant #2's file revealed diagnoses including severe recurrent major depression with psychotic features, anxiety, hypertension, coronary artery disease, obstructive sleep apnea syndrome and type 2 diabetes mellitus with complication without long-term current use of insulin. Tenant #2 was discharged on 3-19-18. 2. Resident Profile Notes revealed the following: a. On 3-13-18 it was noted Tenant #2 went to the Emergency Room (ER) on 3-10-18 due to shortness of breath (SOB). Tenant #2 returned and with an order to start on sliding scale insulin. Tenant #2 was unable to complete this task, and universal workers were also unable to draw up and administer insulin. The Nurse called the doctor and left a message regarding holding the insulin until Monday (3-19-18) due to the inability of the Program to meet his/her needs and a care plan meeting with Tenant #2 would be set for that day. b. On 3-19-18 it was noted Tenant #2's blood glucose was high on 3-16-18 and the ambulance was called to take him/her to the hospital. The Nurse went to the hospital on 3-17-18 and explained about the care conference and calling the doctor. Tenant #2 was transferred to a higher level of care on 3-19-18. 3. Review of a hospital discharge summary revealed Tenant #2 was seen in the ER on 3-10-18. Follow up orders included glucose monitoring four times a day (before meals and at bedtime) and Humalog insulin (sliding scale) four times per day (with meals and at bedtime). The order date and start date provided was 3-11-18. The discharge summary with physician orders was not noted with time, date or signature.	**$2000.00**

	4. Review of the tenant's March 2018 medication administration record (MAR) indicated blood glucose monitoring was added to the MAR at 7:00 a.m., 11:00 a.m., 4:00 p.m. and 10:00 p.m. There was only one recorded blood glucose reading from the time it was ordered (3-11-18) until Tenant #2's hospitalization (3-16-18); however, that blood glucose reading of 431 was documented for 4:00 p.m. on 3-20-18, four days after the tenant was hospitalized. The Humalog sliding scale insulin was added to the MAR at 7:00 a.m., 11:00 a.m., 4:00 p.m. and 10:00 p.m. There were no documented doses for the administration of Humalog from the time it was ordered until Tenant #2's hospitalization. Prior to the ER visit the tenant took oral medications for diabetes mellitus which he/she continued to receive. 5. During interviews conducted on 3-26-18 (10:43 a.m. and 2:32 p.m.) and 4-9-18 (10:35 a.m.) the Nurse reported the Program's policy indicated insulin could not be administered per vial and tenants had to self-administer insulin. Staff could dial up the insulin pen and tenants would need to inject it. Regarding blood glucose monitoring, staff prepared the supplies for a blood glucose check and the tenant completed the needle stick. Further interview revealed Tenant #2 went to the hospital with SOB on 3-10-18 (Saturday) and returned during the early morning of 3-11-18 with orders for sliding scale Humalog and blood glucose monitoring four times per day. Staff informed the Nurse of Tenant #2's ER visit. An assessment was not completed on Sunday (3-11-18) as there was no change in Tenant #2's status and he/she had not been admitted to the hospital. On Monday the Nurse saw the orders for Tenant #2 and contacted the corporate nurse without success to see if sliding scale insulin could be administered. Staff reported they were not allowed to draw up insulin from a vial. Local pharmacies were closed on Sundays and the ER or Urgent Care clinic typically sent any new medications with a tenant to get them through the weekend if necessary. Because nothing was sent back with the tenant from the ER, the Nurse contacted the pharmacy on Monday regarding the new orders. The pharmacy had not received the prescriptions from the ER so the Nurse faxed them over to the pharmacy. On Tuesday (3-13-18) in the afternoon the pharmacy sent the supplies for Tenant #2's blood glucose monitoring and the insulin in a vial. On 3-13-18, the Nurse called the doctor and left a message indicating the insulin that was sent could not be administered and left a cell number to call back if needed. A response was not received and she found out after the fact the doctor's nurse had not been available. The Nurse was not sure if her voicemail was ever heard. The insulin issue was not discussed with Tenant #2; however a care conference was scheduled with him/her for Monday 3-19-18. The nurse acknowledged she should have followed -up with the primary care provider if she didn't receive a response. The Nurse was not in the building on Wednesday, Thursday or Friday of the week following the Tenant #2's ER visit and there was no nurse present in her absence. The Nurse remained on-call during that time period and there was a corporate nurse out of state who could be called if needed. The Program planned on hiring a back-up nurse;	

	however, there was not a back-up nurse available at the time Tenant #2 returned from the ER. The Nurse stated home health providers could assist in her absence if a referral was made by a tenant's primary care provider. On Friday, 3/16/18, Tenant #2 didn't feel well and blood sugars were high. He/she went to the hospital and transferred to a higher level of care from there. There was one blood glucose check documented on that day, but the tenant received no insulin. The Nurse was unsure why the blood glucose checks were not completed and indicated they should have been done. 6. Review of the Program's policy dated 1-29-18 regarding blood glucose checks identified the protocol for an Accu-Check which included, cleansing the tenant's fingertip thoroughly with an alcohol swab, turning on the machine, loading the tenant's strip into their machine, poking the tenant's finger with a lancet, lightly squeezing the finger until a large drop of blood had formed and lightly apply the tenant's drop of blood onto the strip. Review of the Program's policy dated 1-19-18 regarding insulin injections revealed the use of an insulin pen was the preferred method of administering sliding scale insulin. The use of insulin vials was discouraged as only nursing staff were to draw up insulin and they were not onsite 24 hours a day. 7. Review of a standard occupancy agreement revealed an involuntary transfer section; however, there was nothing specific regarding not allowing insulin syringes and vials in the agreement. 8. In summary, Tenant #2 went to the ER on 3-10-18 with SOB and returned with new orders for sliding scale insulin and blood glucose monitoring four times per day. The supplies and medication for Tenant #2 did not arrive until 3-13-18. It was determined the universal workers could not administer the sliding scale insulin. A message was left for the doctor regarding the inability to administer sliding scale insulin or monitor blood glucose levels; however, a return acknowledgement of the message was not received. The Nurse was gone from the building the next three days and while she was on-call there was no nurse in the building in her absence. On 3-16-18 Tenant #2 had a blood glucose reading of 431 and was sent to the hospital. Tenant #2 did not receive the sliding scale insulin or blood glucose checks as ordered from the time of discharge from the ER until Tenant #2 was sent out to the hospital on 3-16-18.	
69.26(1)	**481—69.26(231C) Service plans.** **69.26(1)** A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. Based on interview and record review the Program failed to update service plans as needed for 1 of 2 former tenants reviewed (Tenant #2). Findings follow:	

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	1. Review of Tenant #2's file revealed diagnoses including severe recurrent major depression with psychotic features, anxiety, hypertension, coronary artery disease, obstructive sleep apnea syndrome and type 2 diabetes mellitus with complication without long-term current use of insulin. Tenant #2 was discharged on 3-19-18. 2. A Resident Profile Note dated 3-13-18 indicated the tenant went to the Emergency Room (ER) on 3-10-18 due to shortness of breath (SOB). Tenant #2 returned with orders for sliding scale insulin. 3. Review of a hospital discharge summary revealed Tenant #2 was seen in the ER on 3-10-18. Follow up orders included glucose monitoring four times a day (before meals and at bedtime) and Humalog insulin (sliding scale) four times per day (with meals and at bedtime). It also included instructions to elevate the head of Tenant #2's bed to 45 degrees. 4. Tenant #2's Master Care Plan dated 7-14-17 was not revised to include blood glucose monitoring four times per day, sliding scale insulin four times per day or the elevation of the head of the bed to 45 degrees. 5. On 7-19-18 at 10:35 am the Nurse confirmed the service plan was not updated after Tenant #2's return from the ER.	