

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

Date: June 9, 2017
Program Name: Senior Star at Elmore Place - AL
Address: 4500 Elmore Ave. Davenport, IA 52807
Type of Action: self-reported incident investigation
Date(s) of Action: May 23, 2017 to May 31, 2017

State Rule #	State Rule	Amount of Civil Penalty
67.5(6)d	<p><u>481—67.5(231B,231C,231D) Medications.</u> Each program shall follow its own written medication policy, which shall include the following:</p> <p><u>67.5(6)</u> When medications are administered traditionally by the program:</p> <p><u>d.</u> Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</p> <p>Based on interviews and record reviews, the program failed to implement physician's orders as written for 1 of 1 tenants reviewed regarding Incident #68207 (Tenant #1). Findings include:</p> <p>A review of Tenant #1's file revealed an admission date of 3/29/16. Physician's orders dated 5/10/17 revealed an order for Tenant #1 to begin hospice services in conjunction with an order for the following medications: Lorazepam 2 mg to be given every 2 hours as needed and morphine 0.25mL to be given every hour as needed.</p> <p>According to a document dated 5/18/17 written by Staff B (LPN), shortly after 8:00 AM on 5/17/17 Staff A (CNA and medication manager) requested she evaluate Tenant #1 due to shortness of breath. Staff A and Staff B observed Tenant #1 with breathing difficulties, change in color and mottling of the extremities. Staff B requested Staff A administer a dose of morphine to Tenant #1 according to the physician's orders. Staff B did not witness Staff A give the medication. On 5/17/17 at approximately 9:00 AM, Tenant #1's hospice nurse arrived to assess the tenant. Staff B was also present. Tenant #1's hospice nurse requested the tenant receive a dose of both Lorazepam and morphine at that time due to agitation and continued labored breathing. Staff B instructed Staff A to administer the medications. When Staff A returned, Staff B noted the medications were in a med cup and</p>	\$1000.00

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not in a syringe. When questioned, Staff A said she had mixed the two meds together. Staff B checked on the tenant around noon, and noted he/she appeared agitated and uncomfortable. Staff B instructed Staff A to give the tenant another dose of both medications and left the room. At approximately 2:00 PM Staff B was notified by Staff D that while he and Staff A e completed the 2:00 PM narcotic count, he noted the count of morphine was incorrect. Staff D said the bottle contained roughly 24mL. Staff B knew there had been 29.75mL at 6:00 AM that day as she had done the count herself. Staff B then asked Staff A how much morphine she had been giving and in what type of device had she been measuring it. Staff A said she had used a med cup and filling it to the 2.5mL line for the 8:00 AM and 9:00 AM doses, but had used the syringe at the 12:15 PM dose after being educated to do so by Staff C (LPN). Staff B realized Staff A had made a medication error and notified the Director of Nursing. They immediately went to assess Tenant #1. They notified the hospice nurse and were advised to send the tenant to the hospital.

When interviewed on 5/24/17 at 10:26 AM, Staff I (LPN) stated she called 911 and was present when the paramedics arrived. She observed the tenant's respirations were off and he/she was unresponsive. The paramedics gave the tenant a nasal dose of Narcan which appeared to be ineffective so it was administered by IV. The tenant remained unresponsive but blood pressure and respirations began rising. According to a document written by Staff I, the physician at the hospital who saw Tenant #1 on 5/17/17 told her on the phone that he would not sign the Major Injury form because his opinion was the tenant died of respiratory failure based upon condition upon arrival at the hospital, comorbidities and receiving hospice services. He stated the amount of morphine the tenant received was not a lethal dose and the Narcan should have reversed the effects of the morphine, however there would be no way of knowing.

On 5/24/17 at 9:40 AM, Staff A stated she noted the order for morphine was for 0.25mL to be given every hour as needed. Staff A stated she had never administered morphine before but had been delegated by the RN at the facility and had completed a medication manager course. She said she had taken a plastic medication cup and poured the morphine to the bottom line of the cup which she assumed was the measurement for 0.25mL. She confirmed she measured the morphine this way for both the 8:00 AM and 9:00 AM doses. As she was preparing the 9:00 AM meds, Staff C entered the area and questioned why the meds were in a cup instead of syringes. Staff C instructed her to utilize syringes for these medications going forward. She stated she had administered the correct dose of morphine to Tenant #1 at

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	<p>12:14 PM on 5/17/17.</p> <p>Review of Staff A's file revealed RN delegation training was completed on 3/9/17. The staff was separated from employment at the program on 5/18/17.</p> <p>On 5/25/17 at 2:00 PM, the Director confirmed the above findings.</p>	
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