

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 6881		Date: November 21, 2018		
Facility Name: Manorcare Health Services Davenport		Survey Dates: November 7, 8 &13, 2018		
Facility Address/City/State/Zip 815 East Locust Street Davenport, IA 52803		MW		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.19(2)a	<p>58.19(2) Medication and treatment. a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)</p> <p>DESCRIPTION:</p> <p>Based on clinical record review, Advance Registered Nurse Practitioner (ARNP) and staff interviews, the facility failed to ensure one of four residents reviewed remained free of a significant medication error. (Resident #1) The facility census was 75 residents.</p> <p>Findings include:</p> <p>1. The Admission Record Report printed November 8, 2017, documented Resident #1 had diagnoses of Schizophrenia and Diabetes Mellitus.</p> <p>The Minimum Data Set assessment dated 8/29/18, documented the resident required extensive assistance with bed mobility, transfers, toilet use and personal hygiene and had short and long term memory problems.</p>	I	\$3750 (Held in Suspension)	UPON RECEIPT
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Facility Administrator

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	<p>The Plan of Care directed staff to administer medications as ordered by the physician.</p> <p>An Incident Report dated 10/26/18 at 5:30 a.m., revealed the resident was administered another resident's medications at 5:30 a.m., resulting in lethargy, altered mental status and further evaluation at the emergency room was required.</p> <p>The Medical Practitioner Progress Note dated 10/26/18 at 12:26 p.m., revealed the resident was seen for sudden onset of drowsiness, slurred speech and unable to understand words (which was not normal). The resident was unable to keep their eyes open during the examination, had increased weakness and decreased strength on the left side. The nurse reported the resident ate all of their breakfast and appeared fine at that time. The pulse saturation level was initially 85% to 86% on room air. Oxygen was applied at 2 Liters and the pulse saturation was up to 94%. During the examination the nurse reported the resident mistakenly received the wrong medications. Further investigation revealed the resident did not receive their own medications. During the assessment and chart review the resident became more lethargic, was unable to respond to questions, was responsive to painful stimuli only, had increased drooling and was</p>			
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	<p>unable to hold their head up or control their oral secretions. The resident was transported to the emergency room with the medication list and a list of wrong medications ingested.</p> <p>The resident ingested Resident #2's medication on 11/7/18. Resident #2's medications included:</p> <ul style="list-style-type: none"> a. Wellbutrin (antidepressant) 150 milligrams (mg) one tablet. b. Citrus Calcium 200 mg - Vitamin D 3 250 mg tablet. c. Clozapine (antipsychotic) 100 mg tablet. d. Ferrous Sulfate one tablet. e. Magnesium Oxide one tablet. f. Metoprolol tartrate 25 mg tablet. g. Omeprazole 20 mg tablet. h. Therems vitamin one tablet. i. Vitamin D3 1,000 units one tablet. <p>The Discharge Summary revealed the resident was hospitalized from 10/26/18 to 10/28/18 for toxic encephalopathy (disease of brain) and possible urinary tract infection. The summary revealed the resident took inappropriate medications and had subsequent unresponsiveness. On Medics arrival the resident responded to painful stimuli, did not answer questions or open their eyes. On arrival</p>			
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	<p>to the emergency room the resident had stable vital signs, was somnolent but spontaneously opened their eyes. Laboratory tests revealed the resident had mild lactic acidosis of 2.8 and a Sodium level of 130 (perhaps chronic). Several hours later, the resident was fully conscious and alert and unable to provide history. The resident remained nothing by mouth until mentation improved and the resident was alert. No infectious etiology identified except the resident had positive urine cultures and was treated with ceftriaxone. The resident was afebrile and without leukocytosis or symptoms.</p> <p>During interview on 11/8/18 at 8:16 a.m., Staff B, licensed practical nurse, LPN reported Staff A, LPN reported she left Resident #1's medications in the resident's room and still needed to administer them before she left. Staff B reported she found medications in a cup on the rail in the hallway. Staff B did not know who the medications belonged to and discarded them. Staff B reported Staff C, certified nurse aide, CNA exited the resident's room and reported finding pills in the resident's room. Staff B told Staff C to tell the resident to take the medications. After breakfast Staff C reported to Staff B the resident was not acting right. Staff B reported the resident was alert but not acting right. Staff B had the</p>			
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	<p>Nurse Practitioner check on the resident. Then Resident #2 reported they did not receive their morning medications. Staff B reported Staff A should have administered Resident #2's medications. Staff D, registered nurse, RN called Staff A to inquire about Resident #1's medications. Staff B reported she made a poor decision by having the resident take the medications that were left in the room without checking them.</p> <p>During interview on 11/8/18 at 8:39 a.m., the ARNP stated she was with the resident about 20 minutes when asked to examine her. She applied oxygen and was unable to hold her head up and was declining rapidly so she made the decision to send the resident out.</p> <p>During interview on 11/7/18 at 2:43 p.m., Staff D, RN reported calling Staff A to inquire about Resident #2's medications. Staff A reported she left Resident #2's medications in Resident #1's room. Staff D reported that was when they realized what was going on with Resident #1. Staff D reported Staff B reported finding medication on the rail in the hall and threw them away. Staff D reported the pills found in the hall were likely Resident #1's medications.</p>			
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	<p>During interview on 11/7/18 at 8:56 a.m., Staff C, CNA reported finding medications in Resident #1's room and told Staff B. Staff B directed Staff C to tell the resident to take the pills. Staff C reported she went back in the room and told the resident to take the medications. Staff C reported the resident took the medications. Staff C reported after breakfast the resident was not acting right and reported the behavior to the nurse.</p> <p>During interview on 11/7/18 at 7:27 p.m., Staff A reported Resident #1 yelled out for help as she was about to deliver Resident #2's medications. Staff A entered Resident #1's room with Resident #2's medications and set the medications down on a tray table. Staff A told Resident #1 to wait a minute and she would be back. Staff A remembered she needed to obtain a laboratory specimen for another resident and left the room. Staff A forgot to pick up Resident #2's medications and reported she did not recall setting up Resident #1's medications.</p> <p>FACILITY RESPONSE:</p>			
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