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

Date: July 28, 2025
Program Name: Windsor Manor Grinnell
Address: 229 Pearl Street Grinnell, Iowa 50112
Type of Action: 129854-I
Date(s) of Action: 7/11/25 – 7/115/25
Citation #: 10866

State Rule #	State Rule	Amount of Civil Penalty
67.5(2)f(4)	**67.5(2) Each program shall follow its own written medication policy, which shall include the following:** **f. When medications are administered traditionally by the program:** **(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.** Based on interview and record review the Program failed to consistently follow its medication policy resulting in a medication error. This pertained to 1 of 1 tenant identified in self-report 129854-I (Tenant #1). Findings follow: Record review on 7/11/25 revealed an incident report (IR) dated 7/8/25 at 10:10 a.m. Staff A notified the nurse she administered another tenant's medication to Tenant #1. Medication administered by mistake included glimepiride 4 mg (used for diabetes), losartan potassium 50 mg, (used for high blood pressure) lovastatin 20 mg (used to lower cholesterol), metformin hcl ER 500 mg (used for diabetes), metoprolol succinate 100 mg (used for high blood pressure), verapamil ER 180 mg (calcium channel blocker), and magnesium oxide 400 mg (antacid). Review of Tenant #1's file revealed he was 77 years old with diagnoses of Parkinson's Disease, heart failure and osteoarthritis. Per physician's orders dated 7/8/24 the Program was to implement 30 minutes checks of blood pressure and pulse and seek emergency care if development of hypotension or bradycardia. At 2:24 p.m. the physician also ordered monitoring of blood glucose for hypoglycemia. The nurse directed staff to check Tenant #1's blood glucose every four hours. The Program monitored Tenant #1 per physician's orders throughout the day/night of 7/8/25 and 7/9/25. At 8:26 a.m. on 7/9/25 Tenant #1's blood glucose measured 27. He sat up in bed, staff gave him glucose gel but he tenant could not swallow. Staff called 911. The nurse attempted to assess Tenant #1 who was diaphoretic and sitting up in bed but unable to respond. Tenant #1 remained unresponsive, emergency medical services (EMS) arrived 8:45 a.m. and administered Nasopharyngeal glucose and then D50 (50% dextrose in water). Tenant #1 became responsive and was talking when EMS	**$5000.00**

	left the facility to transport him to the hospital. The hospital released Tenant #1 on 7/9/25 with his son for a 10-day trip. Record review on 7/14/25 revealed the Program's Assistance with Medications and Treatments policy (undated). The policy directed staff must follow the six rights for proper and accurate administration of medications. Further review revealed the "right resident" - the identity of the resident must be confirmed to ensure the right person receives the medication. Record review on 7/15/25 revealed Staff A's Medication Management Agreement signed on 1/17/23. Review of the document revealed the agreement clearly stated medication errors included medication given to the wrong tenant. Staff A's signature on the agreement signified her understanding of ensuring medications are administered to the right tenant. Further review revealed Staff A's Nurse delegation for bubble packs signed 1/17/23 this document also directed the staff to follow the six rights of medication administration. When interviewed on 7/15/25 at 11:00 a.m. and 11:10 a.m. Staff B and C confirmed following policy and procedure and the six rights is standard practice to ensure tenants receive the right medications. They both added a staff person should never prepare two tenants' medications at the same time in order to avoid mistakenly administering the wrong medication to the wrong tenant. When interviewed on 7/15/25 at 11:30 a.m. the Director confirmed Staff A failed to follow the Program's medication policy and procedure when she prepared Tenant #1 and #2's medications at the same time. Staff A admitted this resulted in her administering Tenant #2's medications to Tenant #1. Staff A had been terminated for the medication error..	