Iowa Department of Inspections, Appeals & Licensing
Health & Safety Division
Adult & Special Services Unit
Civil Penalty Citation

Date: February 17, 2025
Program Name: Parker Place Retirement Community
Address: 707 Highway 57 Parkersburg, IA 50665
Type of Action: 122690-C, 124506-C, 124872-C, 124058-C
Date(s) of Action: between 12/9/24 and 1/9/25
Citation #: 10744

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 follow physician's orders relating to medication and labs for 5 of 15 current tenants reviewed (Tenants #5, #4, #3, #6 and #1). Findings include, but are not limited to: 1) Record review on 12/11/24 revealed Tenant #5 was 83 years old, with diagnoses including diabetes, occlusion and stenosis of unspecified carotid artery, obesity and dementia. Tenant #5 received oral medications and insulin to manage his diabetes. According to his most recent service plan, dated 11/05/24, the program provided medication management services. On 12/12/24 at 8:30 AM Tenant #5's primary care provider (PCP) expressed concern regarding the program's management of the tenant's diabetes. The PCP stated Tenant #5 was recently hospitalized related to low blood sugar (BS). The PCP said Tenant #5's blood sugars had been running high in November 2024, so she increased his insulin dose (medication used to treat high BS). The PCP later reviewed Tenant #5's November 2024 Medication Administration Record (MAR), which showed he did not always receive his insulin as ordered and staff had not consistently checked his BS four times per day, as ordered. Review of Tenant #5's physicians orders, MAR and BS log for November 2024 revealed the following: a. An order for Lantus (insulin) 62 units in the morning from 11/01/24 to 11/11/24. The Lantus was increased by the PCP to 64 units on 11/12/24 and then again increased to 66 units on 11/19/24, due to high BS levels. The order for PM Lantus was increased from 40 units to 42 units on 11/18/24. Additional orders included checking BS	**$7500.00**

	readings four times per day: 7:00 AM., 11:00 AM, 4:00 AM and 8:00 AM. Report to nurse if BS above 400 or below 65. Give Glucose chewable 4mg tablet if BS under 60, if no improvement after 15 minutes, may repeat. Tenant #5 also received Metformin and Glipizide (oral medications used to treat diabetes) twice per day. Tenant #5 used a Dexcom device to monitor his blood sugar readings. b. AM doses of Lantus were not documented as given on 11/9/24, 11/10/24 and 11/11/24. PM doses of Lantus 40 units were not documented as given on 11/08/24, 11/09/24 and 11/10/24. There was no explanation on the MAR or in progress notes regarding why the Lantus was not given. c. The November MAR blood sugar log indicated the staff failed to document the blood sugar reading ten times between 11/01/24 and 11/29/24. d. The blood sugar log revealed a blood sugar of 428 at 8:00 p.m. on 11/12/24. Nursing progress notes indicated staff notified the nurse of the high BS and she provided directives. e. Nursing progress note for 11/18/24 indicated BS of over 400. PCP notified and increased Lantus to 66 units in AM and 42 units in PM. f. Nursing progress note on 11/21/24 noted BS reading of 440 at 7:45 p.m. PCP notified. g. Blood sugar log noted BS was 59 on 12/05/24 at 7:00 AM. According to the orders in place, staff should have notified the program nurse of the low BS and the tenant given a glucose tablet, with a 15 minute check. There was no documentation this was done. The MAR reflected Tenant #5 received his routine 8:00 AM Lantus injection. h. Nursing progress note on 12/05/24 indicated Tenant #5 received first injection of Mounjaro (non-insulin diabetic medication) in the morning. When staff went to get him for lunch, his BS reading was "urgently low." Orange juice and glucose tablet brought BS up to 76. Tenant #5 requested 911 be called and he went to the emergency room, where he was admitted to the hospital. The progress note provided no information regarding a BS of 59 on the morning of 12/05/24. i. November MAR had no documentation of a Mounjaro injection given on 12/05/24. j. Nursing progress note on 12/06/24 indicated Tenant #5 returned to the program after an overnight stay at the hospital. According to the note, Tenant #5 had hypoglycemia related to medication. New orders were to discontinue the Mounjaro and Glipizide and to continue Metformin and Lantus 62 units in AM. k. Nursing progress note on 12/11/24 noted multiple new orders from the PCP related to diabetes management, which included the following: call the PCP office if BS under 60 and hold insulin until hear back from provider; give a glucose tablet or juice for BS under 70 and recheck fingerstick glucose after 15 minutes; call office - do not fax - if BS below 70 and does not respond to glucose tablet or juice; if no Dexcom reading or if reading is below 70 or above 375 - double check reading with finger prick; check BS at 3:00 AM and 5:00 AM and give food if under 80. These orders were not listed on the December or January MAR.	

	On 12/12/24 at 1:20 PM the Clinical Educator (the covering registered nurse) said she didn't know why Tenant #5's Lantus was not documented as given from the evening of 11/08/24 through the morning of 11/11/24. She said she wasn't made aware the Lantus wasn't given during that time. On 1/06/25 at 1:10 PM the Clinical Educator (CE) confirmed no documentation on the December MAR for the Mounjaro injection given on the morning of 12/05/24. She said she saw the staff person give Tenant #5 the injection. The CE indicated she didn't know why the injection was not documented on the MAR. Regarding the low BS of 59 on the morning of 12/05/24, the CE confirmed staff should have notified the nurse and given the tenant glucose or juice, but there was no documentation of this. The CE verified the order to notify the PCP office for BS under 60 and to hold the insulin injection until the program heard back from the provider was not listed on the December MAR after 12/11/24 or on the January MAR. She noted there was an order on the MAR to notify the nurse if the BS was under 65 and the nurse would contact the PCP office if BS was under 60. The CE also confirmed the MAR had an order to give a glucose tablet for BS under 70, but it did not indicate the BS should be checked again by a finger prick 15 minutes later or to notify the PCP office if the there was no response to the juice/glucose. She confirmed the MAR also failed to include the 3:00 AM and 5:00 AM blood sugar checks, with food given for BS under 80. The CE said she thought the 3:00 AM and 5:00 AM blood sugar checks were on the overnight task sheets, but was unable to locate this information. 2) Review of a PCP visit note dated 7/22/24 revealed the tenant was seen at her apartment to establish care and for concerns of agitation and anxiety. Tenant #4's diagnoses included Alzheimer's disease, dementia with agitation, history of pulmonary embolism (PE) and chronic anticoagulation. Tenant #4 was previously prescribed 5 mg. of Warfarin once daily (every day except Friday) and 7.5 mg. of Warfarin on Friday. Warfarin is a medication used to prevent blood clots. The provider requested the program send a copy of Tenant #4's last INR, a lab test indicating how long it takes blood to clot, as well as have the lab repeated. She was to return to see the new PCP in two weeks. Tenant #4's service plans dated 5/10/24 and 9/6/24 revealed the program administered her medication. A review of PCP visits notes, MARs, pharmacy records and progress notes revealed the following: a. Tenant #4 returned to see her new PCP on 8/8/24. The PCP's note revealed the tenant had not been receiving Warfarin since approximately 7/21/24 because it was not re-ordered by the former PCP. The program did not follow-up with the former provider to ensure the tenant had her medication. Tenant #4 had a history of Pulmonary Embolism (PE) requiring chronic Anticoagulation. The new PCP re-ordered the Warfarin on this date, a 30-day supply, with 11 refills. b. A document provided by the program titled "Med Error Warfarin" identified Tenant #4's new PCP did not receive communication or orders on her INR results from 7/29/24. The program nurse	

	investigated by looking at the tenant's EMAR, progress notes, uploaded documents, medication drawer and called the pharmacy. Tenant #4 had not received Warfarin since approximately 7/24/24. Adding to the confusion was the issue staff documented they administered Warfarin to Tenant #4 when there was no medication available on the following dates: 7/25/24, 7/26/24, 7/27/24, 7/30/24, 7/31/24, 8/1/24, 8/3/24, 8/4/24, 8/5/24, 8/6/24 and 8/7/24. c. Tenant #4 met with her physician on 9/9/24 and no concerns were noted. Tenant #4's INR was due on this date. A progress note indicated a lab tech drew blood to test for the INR. d. The pharmacist for Tenant #4 reported on 12/17/24 at 1:17 PM the program had a practice in which the pharmacy could only send out enough Warfarin to cover until the next INR date plus two days. The pharmacy provided a fill history document noting it provided the program with 10 Warfarin tablets for Tenant #4 on 8/30/24 which would have supplied her with enough medication for 9/1/24 - 9/11/24. e. A review of the September MAR revealed staff documented they administered Warfarin to Tenant #4 every day 9/12/24 - 9/30/24 (with the exception of 9/13/24 when it was marked as DNA "did not administer") even though the medication was not at the building to provide to the tenant. f. The program progress notes indicated on 9/30/24 Tenant #4 and her daughter met with her physician and requested to discontinue Warfarin and change to a different anticoagulant medication, Rivaroxaban, where INR checks were not required. g. On 10/15/24 the program received an order from Tenant #4's physician to stop Rivaroxaban due to the cost of the medication. The family wanted to return to using the medication Warfarin. A lab order for an INR on 10/29/24 was placed. The program was to stop Rivaroxaban and begin administering Warfarin 5 mg. daily. h. A review of the October 2024 and November 2024 MARs revealed the program continued to administer Rivaroxaban/Xarelto through the month of October until November 6th. There was no indication they alerted the physician they did not follow her orders and delayed starting the Warfarin. A progress note dated 1/7/25 indicated Tenant #4's daughter notified the nurse she wanted to use all of the Rivaroxaban prior to starting the Warfarin. i. A review of the November 2024 MAR revealed staff began administering Warfarin to Tenant #4 beginning on 11/6/24. Staff documented they administered the medication throughout the month. j. A review of a fill history from the pharmacy indicated 13 pills of 5 mg. Warfarin were dispensed to the program on 11/4/24 to start on 11/6/24. These pills would have lasted until 11/18/24. k. A review of the December 2024 MAR revealed between 12/1/24 - 12/17/24, staff documented they administered 7 pills of Warfarin to Tenant #4. Other entries on the MAR were left blank or staff indicated they did not administer the medication. l. Tenant #4 saw her physician at the program for ear pain on 12/9/24. She was due for an INR and staff were directed to obtain the lab test. The PCP made a medication change to stop Tenant #4's 10 mg. Olanzapine daily and 5mg. AM dose of Olanzapine. The program was to start Tenant #4 on 5 mg. of Olanzapine at noon and bedtime.	

	m. On 12/17/24, Tenant #4 was seen by her physician for a feeling of a plugged ear and a request for an INR. Tenant #4's daughter reported the program asked her to get an INR as they were late in obtaining this test. The PCP informed the daughter she had learned Tenant #4 had not received Warfarin for several weeks. The PCP had contacted the pharmacy and learned a 13 day supply of Warfarin was sent on 11/4/24 with no refills. The PCP ordered a new INR for 12/31/24. The PCP noted Tenant #4's medication change to Olanzapine from 12/9/24 had not been made and asked the program to correct it. n. A review of progress notes indicated Tenant #4 was unable to get her INR test when the program tried to arrange this on 1/2/25 (the INR was due on 12/31/24). The PCP called the program on 1/3/25 and staff took the tenant to the hospital for the lab on that date. Tenant #4 discharged from the program on 1/4/25. 3) Record review on 12/16/24 revealed Tenant #3 was diagnosed with hypertension, depression, hyperlipidemia, alzheimer's disease, dementia with mood disturbance and COPD (chronic obstructive pulmonary disease). A review of service plans dated 1/5/24 and 9/9/24 noted staff were responsible for administering Tenant #3's medication. a. A note from Tenant #3's PCP dated 5/13/24 identified she had a history of a GI (gastro-intestinal) bleed. She directed the program to discontinue Tenant #3's Pantoprazole Sodium, 40 mg. She noted this medication was discontinued at the last appointment as well, but remained on the medication list. The PCP ordered the following labs due to hyperlipidemia, hypothyroidism and hypertension, respectively: lipid profile, TSH (test to check thyroid level) and comprehensive metabolic panel. b. A review of labs ordered on 5/13/24 revealed they were not completed until 7/1/24. Tenant #3's TSH was elevated, a value of 15.7 when a normal value is 0.27 - 4.20. The PCP increased her Synthroid dosage from 88 mcg. to 100 mcg. daily. c. Tenant #3 returned to see her PCP on 7/16/24 according to a visit note. Her Pantoprazole had been discontinued in both March and May but remained on the medication list. The PCP discontinued it again. The PCP directed the program to check the tenant's TSH (thyroid level) on 8/14/24. d. A review of the program MARs revealed Pantoprazole Sodium 40mg. was administered from 4/1/24 through the morning of 7/2/24. e. The program submitted medication orders to Tenant #3's PCP for review on 9/9/24. The PCP signed these and added a note reminding them the tenant was overdue for a TSH (ordered for 8/14/24). If the lab could not be drawn at the program, they could bring Tenant #3 to the clinic. f. Tenant #3 was seen at the program on 9/12/24 by her PCP following a hospitalization for community acquired pneumonia, hypoxia and enterocolitis from 9/1/24 to 9/6/24. The PCP again ordered the TSH which the program had not obtained.	

	g. The PCP met with Tenant #3 at the program on 10/15/24 for a follow up appointment. Tenant #3 had not yet received a TSH to monitor her thyroid level. h. Tenant #3 received her TSH lab test on 11/7/24. (Originally ordered on 8/14/24. Re-ordered on 9/12/24). The result was 16.00, with a normal range of 0.27 - 4.20. The PCP increased the tenant's Synthroid from 100 mcg. daily to 125 mcg. daily. 4) On 12/23/24 at 10:55 AM observations revealed Staff F prepared Tenant #6's Oxycodone 2.5 ml by placing it in thickened juice. Staff F handed the glass of juice with Oxycodone in it to Tenant #6. Tenant #6 diagnoses included polyneuropathy, polyosteoarthritis and dementia. According to her most recent service plan, dated 9/09/24, Tenant #6 began hospice services on 3/15/24 related to end stage dementia. Tenant #6's December physician's orders included orders for regularly scheduled Oxycodone oral solution 2.5 ml two times per day at 6:00 AM and 6:00 PM, and Oxycodone oral solution 2.5 ml as needed (PRN), every six hours. Tenant #6's December MAR revealed she received no PRN Oxycodone during the month. The December narcotic count sheet for the PRN Oxycodone also indicated it was not given. The MAR indicated Staff F documented she administered the 6 AM Oxycodone on 12/23/24. On 1/08/25 at 9:10 AM, Staff F confirmed she passed Tenant #6's medication on the morning of 12/23/24 in the presence of a state surveyor. Staff F didn't recall if she administered Tenant #6's AM Oxycodone when observed or if she administered the PRN Oxycodone. When told the MAR and the narcotic count sheet showed no PRN Oxycodone was given on 12/23/24, Staff F said she must have given Tenant #6 her 6:00 AM dose at approximately 11:00 AM. Staff F indicated she probably gave the medication late because she was the only staff person working in the Memory Care unit that morning. She usually got Tenant #6 up last in the morning because she needed supervision when eating. On 1/08/25 at 11:30 AM, the Clinical Educator confirmed tenant medication should be passed around the time noted in the physician orders. She said the expectation was for medication to be passed within an hour before or an hour after the specified time. Tenant #6's 6:00 AM Oxycodone should have been administered by 7:00 AM. The Medication and Medication Administration policy indicated specific timing may be important for certain drugs to be effective. If a certain time was specified for a medication, it needed to be given only at that time. 5) Record review on 12/10/24 revealed Tenant #1 had a diagnosis of unspecified dementia. A hospital discharge note revealed he was	

	hospitalized from 11/2/24 to 11/5/24 with sepsis, acute metabolic encephalopathy, acute cystitis, transaminitis, lactic acidosis, hypokalemia, hyponatremia and E coli bacteremia. Tenant #1 completed his antibiotic on 11/14/24 without any signs of infection remaining. His 11/6/24 service plan noted staff were responsible for administering his medication. a. On 12/9/24, Tenant #1 saw his PCP for a routine visit according to the visit note. Staff reported Tenant #1 was experiencing urinary frequency. A lab was ordered for a urinalysis and culture due to the urinary frequency. b. On 12/24/24, the 60-day medication orders were sent to the PCP by the program. The PCP signed the orders and added a note she was waiting for results of the urinalysis ordered on 12/9/24. Staff were notified to collect the urine sample. c. On 12/27/24, a urine sample was sent to the lab. The urine was assessed as acute cystitis with hematuria. The PCP ordered Cipro 500 mg., twice daily for 5 days. The Clinical Educator confirmed these findings on 1/8/25 at 4:35 PM.	