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

Date: October 11, 2024
Program Name: Friesland AL and Zeeland Memory Support at the Cottages
Address: 1742 Main Street Pella, IA 50219
Type of Action: 123088-I, 123344-C
Date(s) of Action: 9/4/24 – 9/12/24
Citation #: 10631

State Rule #	State Rule	Amount of Civil Penalty
67.5(2)f	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 ensure medication was administered as prescribed for 1 of 1 former tenants reviewed (Tenant C1). Findings follow: 1. On 9/04/24 record review revealed a program investigation regarding Tenant C1. The Licensed Practical Nurse (LPN) found Tenant C1 lying on the floor of his room on the afternoon of 8/23/24. He was bleeding from his nose and had an injury to his forehead. The tenant went to the local emergency room (ER) by ambulance. Tenant C1 remained at the emergency room for approximately three hours. He was released back to the program with diagnoses of pneumonia, enterovirus infection and contusion (forehead). Tenant C1 returned to the program at approximately 6:30 p.m. accompanied by his wife. Staff reported the tenant showed signs of increased confusion. He became less responsive and went back to the ER at approximately 7:45 p.m. A CT (computed tomography) scan of his head showed a new large acute subdural hematoma along the left hemisphere. Tenant C1 remained at the hospital and passed away at approximately 5:00 a.m. on 8/24/24. According to the program investigation, Tenant C1 had previous falls when he was found on the floor at 11:00 p.m. on 8/22/24 with no apparent injury, and at 2:15 a.m. on 8/23/24 with no apparent injury. Head injury screens were negative. The doctor was notified on the morning of 8/23/24 with no new orders. The LPN had notified the Primary Care Provider (PCP) on 8/22/24 of Tenant C1's change in condition, related to shortness of breath, decreased oxygen saturations, low pulse rate, congestion in chest and weakness. The PCP ordered a chest x-ray and labs, including INR (International Normalized Ratio, a blood test that measures low long it takes for blood to clot. INR tests help doctors calculate the best dose of Warfarin/Coumadin for a patient). The INR was high at 4.9. New order received to change Warfarin/Coumadin to 2.5 mg daily.	**$7000.00**

	Tenant C1 didn't get the chest x-ray before going to ER on the afternoon of 8/23/24. The LPN determined on 8/21/24 Tenant C1 received more Warfarin than prescribed from 8/04/24 to 8/20/24. Upon review of medication administration, it was determined staff used a medication planner to administer Warfarin in the morning and the pharmacy provided punch cards of Warfarin given in the evening, which resulted in duplicate doses being given as it was only to be given once a day. The PCP increased the Warfarin dosage on 7/29/24 to 5 mg on Su/Tu/Th and 7.5 mg on M/W/F/S in response to a low INR of 1.4. The pharmacy provided punch cards for the Warfarin on 8/02/24, per the new orders. Prior to this, staff had administered Tenant C1's Warfarin and other medications to him from his medication planner. Staff continued to administer the medications in the planner, in addition to the Warfarin in the punch cards. Staff reported they administered the medications in the medication planner, by crushing them and putting them in applesauce. They said they also administered the evening dose of Warfarin from the punch cards. Medication Manager (MM) A reported Tenant C1's wife told her the program staff filled the medication planners. MM A said she filled the medication planners twice when they were empty (two weeks) in July or early August. She said she followed the medication administration record (MAR) and bottles of medications when she filled the medication planners. The LPN realized the error on the morning of 8/21/24. She removed all Warfarin and notified Tenant C1's PCP. 2. Tenant C1 was an 81 year old male with diagnoses including unspecified symptoms and signs involving cognitive functions and awareness; major depressive disorder, recurrent; anxiety disorder, heart failure, unspecified; diabetes mellitus, type 2 and chronic atrial fibrillation. His wife was power of attorney (POA) for financial and health care decisions. A history and physical completed on 5/22/24 by his new PCP, prior to moving to the program, listed medications at that time, including Warfarin 7.5 mg. Tenant C1 moved to the Zeeland Memory Care unit on 6/03/24. 3. On 9/04/24 at 4:10 p.m. the LPN said Tenant C1's INR was low on 7/30/24. His PCP ordered an increase in Warfarin, with an INR recheck in one week. The program was responsible for the INR blood draw, but overlooked the order to re-check the INR in one week. The LPN said she wasn't aware of the order, which was in Tenant C1's electronic health portal with the medical provider. The former program RN, who left the program in mid-July, got email notices regarding portal messages, but the LPN did not. The LPN said the Long Term Care Director of Nursing (DON) acknowledged the portal message on 7/30/24. The LPN started her position at the program on 7/11/24 and was on vacation the first week of August. She recalled after the former RN left the program, Tenant C1's wife asked the LPN if she would be setting up Tenant C1's medication planner or if the wife should do it. The LPN said she told the wife she didn't care either way. The LPN	

	assumed the wife set up the planners. The LPN later learned MM A set up Tenant C1's medication planner, for two weeks after the former RN left, from bottles of medication brought in by the tenant's wife. Tenant C1 didn't have punch cards/blister packs of Warfarin until after 7/29/24 when the PCP made a change to the Warfarin. The pharmacy sent the punch cards of Warfarin to the program with the new dosages. On the morning of 8/21/24, the LPN reviewed the medication planner and the MAR after another medical provider made a different medication change. The LPN realized staff had been giving Tenant C1 Warfarin in the morning from his medication planner and Warfarin in the evening from the blister packs, which doubled the dose of the prescribed medication. The LPN said she removed all Warfarin from Tenant C's medication planner and medication cabinet on 8/21/24 (after the morning dose of medication) and notified his PCP. Tenant C1 did not receive Warfarin after the morning dose of 8/21/24. The PCP ordered Warfarin 2.5 mg daily on 8/22/24, but the LPN said Tenant C1 didn't receive it prior to going to the ER on 8/23/24. 4. Review of Tenant C1's record and health portal messages revealed the following: Health portal message 7/12/24 from PCP: INR 3.2. Continue Warfarin 7.5 mg daily. Recheck INR one week. Progress Note 7/15/24 regarding fall and visit to ER on 7/13/24: Returned from ER with new orders to hold Coumadin x 1, then decrease to 5 mg daily and recheck INR on 7/17/24. (Not noted on July MAR.) Health portal message 7/19/24 from PCP: Increase Coumadin to 7.5 mg on Monday and Friday. Take 5 mg on all other days. Repeat INR in one week. INR low at 1.8. Normal level was noted as 2.0 - 3.0. (No acknowledgement or documentation by the program regarding this message. No change to MAR. No documentation this increase occurred. The RN left the program around this time.) Health portal message 7/29/24 from PCP: INR was low at 1.4. Increase Coumadin to 7.5 mg Monday, Wednesday, Friday and Saturday and give 5 mg on Tuesday, Thursday and Sunday. The Long Term Care RN acknowledged the message on 7/30/24 with, "Thanks." Health portal message 8/20/24 from LPN to PCP: LPN noted Tenant C1 needed an INR about two weeks ago and questioned if it was missed. She offered to draw the INR and any other labs needed. PCP nurse responded the same morning to do only the INR at that time. (INR draw not done until 8/22/24.) Progress note and Incident Report by LPN on afternoon of 8/21/24: Tenant C1 had a tele-psych appointment with changes to medications. As the LPN went through the medication planner to change medications, she noticed the tenant had Warfarin in his AM medication planner and PM bubble packs of Warfarin. He was getting more Warfarin that prescribed. LPN notified wife and PCP.	

	Portal message from LPN to PCP on 8/22/24 at 9:59 a.m.: LPN noted Tenant C1 began having shortness of breath the day before when ambulating. Heart rate irregular. Oxygen saturations normal. Congestion in chest. Lung sounds not clear in right lobe. Tested negative for COVID. Edema in both lower extremities with +1 or 2 pitting. LPN wrote she thought something new was going on with Tenant C1's heart. She asked if the PCP wanted other labs done when she drew the INR. PCP office responded at 10:06 a.m. to do other blood work and a chest x-ray, in addition to the INR. Portal message from PCP on 8/22/24 at 4:29 p.m.: INR of 4.9. High. Noted program was contacted by phone. (No corresponding progress note.) Incident report 8/22/24 at 11:00 p.m.: Tenant C1 found on floor in room, no apparent injuries. Incident report 8/23/24 at 2:11 a.m.: Tenant C1 found on floor. No apparent injuries. Progress note 8/23/24 at 2:40 a.m.: Tenant C1 very restless this shift. Up multiple times. Restless and combative. Portal message on 8/23/24 at 8:45 a.m. from program to PCP: Notification of two falls during the night. Hematoma to left forehead. Neuro's intact and per usual. PCP responded, "Noted". Incident report and progress note on 8/23/24 at approximately 2:40 p.m. written by LPN: Tenant C1 found on floor of room, bleeding from nose and head. Sent to ER. Notified wife and PCP. ER records for first visit on 8/23/24: Records noted Tenant C1 fell twice during the night and again prior to arrival at ER. He had taken double doses of his blood thinner (Warfarin) for two weeks. INR at ER was 4.0. No pain or signs of distress. CT scan of brain to rule out intracranial hemorrhage, which was negative. Diagnosed with pneumonia and positive for enterovirus. Started on Doxycycline. ER notes indicated they talked with wife about stopping Warfarin since Tenant C1 was a fall risk. Progress note 8/23/24 at 6:48 p.m., late entry: Tenant C1 returned from hospital with new orders for antibiotic for pneumonia. Shortly after returning from ER he had a drastic change in condition and was sent back to ER. ER records for second visit on 8/23/24: Time listed as 8:39 p.m. Noted quick decline in functioning after being home a few hours from earlier ER visit. Minimally responsive during exam. CT of head showed large intracranial bleed, which was incompatible with life. Family chose comfort measures only. INR was 4.1. Discharge problem listed as subdural hematoma, altered mental status and supratherapeutic INR. The ER History and Physical written by ER doctor noted acute subdural hematoma due to recurrent falls and over anti-coagulation.	

	5. Review of Tenant C1's July 2024 MAR revealed an entry for an AM Medtime Planner and a PM Medtime Planner. The AM Medtime Planner indicated to give one of each pill/tablet from the planner, which listed seven medications, including Warfarin 7.5 mg. Staff initialed one entry each day for the AM Medtime Planner. Staff also initialed one entry for the PM Medtime Planner, which contained three medications. Staff initialed all medications were given from the Medtime planners during the month of July. There was no documentation of any change to the Warfarin on or around 7/13/24 or 7/19/24, per PCP orders noted above. New order with a start date of 7/29/24 for Warfarin 5 mg, 1 tablet on Sunday, Tuesday and Thursday. New order with a start date of 7/29/24 for Warfarin 7.5 mg, 1 tablet on Monday, Wednesday, Fridays and Saturday. July MAR had no documentation those medications were given in July. Review of punch cards/bubble packs for July Warfarin revealed the 7.5 mg dose for 7/31/24 was missing and apparently administered. Tenant C1 received 7.5 mg Warfarin from his AM medication planner and from the PM punch card on 7/31/24. 6. Review of Tenant C1's August MAR revealed an entry for an AM Medtime Planner and a PM Medtime Planner, the same as the July MAR. The AM Medtime Planner indicated to give one of each pill/tablet from the planner, which listed seven medications, including Warfarin 7.5 mg. Staff initialed one entry each day for the AM Medtime Planner. Staff also initialed one entry for the PM Medtime Planner, which contained three medications. The Medtime Planners were discontinued on 8/23/24. Staff documented they gave medication from the AM planner through 8/23/24. The August MAR also listed separate entries for Warfarin 5 mg, 1 tablet on Sunday, Tuesday and Thursday and Warfarin 7.5 mg, 1 tablet on Monday, Wednesday, Friday and Saturday. According to the MAR, staff documented they administered the additional Warfarin on August 1, 4, 6, 8, 11, 13, 15, 18 and 22nd. However, there was some discrepancy with the August punch cards/blister packs of Warfarin which showed 5 mg tabs missing for August 4, 6, 8, 11, 13, 15, 18 and 20th and 7.5 mg tablets missing on August 6, 16, 17 and 19. Based on review of the MAR and the Warfarin punch cards, staff administered Warfarin 12.5 mg on August 1, 4, 8, 11, 13, 15, 18 and 22, when Tenant C1 should have received 5 mg. Staff administered Warfarin 15 mg on August 6, 16, 17 and 19, when he should have received 7.5 mg. 7. On 9/09/24 at 2:00 p.m. MM A said staff gave Tenant C1 medications from his medication planner, which was set up for the week, from bottles of medication kept in his locked medication cabinet, along with the medication planner. MM A said staff crushed the medications and mixed them with applesauce in order to get Tenant C1 to take the medications. She thought Tenant C1's wife set	

	up the weekly medication planners. MM A recalled two consecutive weeks she filled the medication planners for the week because they were empty. This was after the RN left the program, between mid-July and early August. MM A said she followed the labels on the bottles of medications and the Medication Administration Record (MAR) when she set up the medical planner for the week. MM A noted other tenants on the unit also used medication planners. When asked if she recalled being trained she should only administer medication she set up, MM A said the RN was her boss and she told MM A to give the tenants the medication from their medication planners. 8. On 9/09/24 at 10:00 a.m. the Senior Clinical Quality Specialist (SCQS) said since the incident with Tenant C1, the program no longer allowed the use of medication planners on the Zeeland Memory Care unit. She said staff were retrained regarding medication administration. The SCQS confirmed medication managers should only administer medications they set up and should not pass medications from a medication planner set up by someone else. 9. On the morning of 9/10/24, the Executive Director (ED) stated the program was unable to determine who set up Tenant C1's weekly medication planners during the month of August. She said it must have been the tenant's wife or a program staff. The Long Term Care DON and the program LPN denied setting them up. Various medications managers denied setting up Tenant #C1's medication planners in August. The Executive Director and LPN reviewed the July and August MARs and Warfarin punch cards with the surveyor and confirmed staff administered excess Warfarin on July 31st and 12 days in August between the 4th and 20th. The ED stated the former RN was filling Tenant C1's weekly medication planners prior to leaving the program on 7/18/24. There were three medication planners in the locked medication cabinet and the nurse filled all three at the same time. The RN likely saw the portal message about the Warfarin change on 7/13/24 and might have made adjustments to the medication planner (no changes made to MAR). The ED confirmed there was no evidence anyone at the program saw the portal message from 7/19/24 regarding new Warfarin orders or made those changes. MM A likely filled the medication planner two weeks in a row during the last two weeks of July, or possibly into early August. She said she followed the Warfarin bottle and MAR when filled the medication planners, both of which indicated 7.5 mg per day. The LPN said she didn't see the portal messages on 7/19/24 or 7/29/24 regarding the changes to the Warfarin orders. The order for the Warfarin increase on 7/19/24 might not have been followed. The INR remained low and the PCP ordered another increase on 7/29/24 and another INR in one week. That ordered was acknowledged by the Long Term Care DON. The pharmacy provided punch cards of Warfarin with the new order, but the old order for Warfarin 7.5 mg daily remained on the MAR, as being given from the AM medication planner. The LPN said she didn't know who set up the Tenant C1's	

	weekly planner in August. When asked why she didn't do the INR draw until 8/22/24 when she noticed it was overdue on 8/20/24 and got an order from the PCP the same day, the LPN indicated she got busy and didn't see the portal message right away. On the morning of 9/11/24 at 11:25 a.m. the Long Term Care RN stated she saw the portal message for Tenant C1 on 7/29/24 regarding the results of his INR and other lab work. She said she didn't see the request to increase the Warfarin and do an INR in one week. She noted the Long Term Care LPN responded to the new order. On the morning of 9/11/24 at 11:30 a.m. the Long Term Care LPN said she entered the new Warfarin order into the computer system/record on 7/29/24 for Tenant C1. The program pharmacy then sent the Warfarin in the punch cards and entered the new orders on the MAR. The LPN said she didn't recall if she entered the order for the INR in one week. On 9/10/24 at 2:25 p.m. Tenant C1's wife said the program informed her on 8/23/24 they had been giving Tenant C1 twice the amount of his prescribed Warfarin and his INR was too high. She said she brought the bottles of Warfarin and other medication to the program, but she did not set up his medication planners. She last took a bottle of Warfarin to the program in July and the label continued to indicate 5 mg, 1.5 pills per day, which had been his daily dosage for a long time. The bottles of medication and medication planners were kept in a locked medication cabinet in her husband's room. Staff gave the medication to the tenant from the medication planners, after mixing the meds with applesauce. She said when Tenant C1 went back to ER for the second time on 8/23/24, the ER doctor said the brain bleed was caused by the blood thinner (Warfarin) being too high. On 9/10/24 at 5:00 p.m. the ER doctor said it was difficult to explain why the brain hemorrhage did not show up during the first visit to the ER on 8/23/24 after Tenant C1 fell and hit his head. He said the elevated INR increased the risk of bleeding. The elevated INR was caused by receiving more Warfarin that prescribed. On 9/11/24 at 1:35 p.m. Tenant C1's PCP said she suspected the fall triggered the brain bleed. It could take a while for the bleeding to show up, which could explain why the first CT scan didn't show it. The elevated INR increased the risk of bleeding. 10. In summary, the program failed to follow physician's orders regarding Warfarin dosages, obtaining INR levels. The recommended INR range for someone on Warfarin is 2.0 to 3.0. Tenant C1 had an INR of 4.9 on 8/22/24, which was very high and increased the risk for bleeding. The program administered the tenant's Warfarin from a weekly medication planner, with several other medications in the same planner. All the medications were listed in the same MAR entry. It was unknown who set up the medication planners in August. There was no documentation of changes to the MAR regarding physician orders to increase/decrease Warfarin on 7/13/24 and 7/19/24. An order change on 7/29/24 was entered on the July and August MAR	

	and the pharmacy sent punch cards of Warfarin corresponding with the new orders. However, the old entry for Warfarin 7.5 mg in the AM medication planner was not discontinued until 8/23/24, after the LPN noticed the error on 8/21/24. Tenant C1 received excess doses of Warfarin for 12 days between August 4th and August 20th. The LPN said she pulled all Warfarin from Tenant C1's medication cabinet and medication planner after his AM dose on 8/21/24. The program also failed to follow the physician's order on 7/29/24 to obtain an INR in one week. The LPN noticed this was overlooked and sent a message to the PCP on the morning of 7/20/24 asking for an order for an INR draw. The PCP office responded the same morning to do the draw, but it wasn't done until 8/22/24, when it was discovered to be 4.9. The elevated INR put Tenant C1 at an increased risk for bleeding. His INR was 4.0 and 4.1 when he went to the ER twice on 8/23/34, after a fall earlier in the day. The second ER visit showed a large brain hemorrhage, which was incompatible with life. The ER doctor and PCP said Tenant #1 was at increased risk for bleeding due to his elevated INR.	