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

Date: February 14, 2025
Program Name: Bickford Cottage Marion
Address: 1100 Linden Drive Marion, IA 52302
Type of Action: recertification visit
Date(s) of Action: 12/18/24, 12/19/24, 1/6/25, 1/7/25
Citation #: 10742

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 administer medications and treatments as prescribed. This pertained to 1 of 1 tenants reviewed who received insulin and blood glucose monitoring (Tenant #4). Findings follow: 1. Review of Tenant #4's file on 1/7/25 revealed an incident report (in Progress Notes) dated 12/13/24 at 9:45 p.m. indicating staff went to her apartment for rounds and found her on the floor foaming from the mouth. Staff called the Health and Wellness Director, turned her on her side and took her blood glucose reading which was 32. The Health and Wellness Director arrived a few minutes later and called 911. Emergency medical services (EMS) arrived and took her to the emergency department (ED). Continued record review revealed ED records indicated she was admitted on 12/13/24 and discharged on 12/14/24. Final diagnoses included seizure, hypoglycemia, hypothermia, and acute non-recurrent maxillary sinusitis. The records indicated she was found on the floor at the Program actively seizing. It was noted she was likely sweating and laying in wet. She had a blood glucose reading of 46 by EMS and hypothermia of 91 degrees. She was given 250 milliliters (ml) of D10 (Dextrose 10%) by EMS and had a repeat blood glucose of 137. She was awake and alert upon arrival to the ED. Per staff at the Program she did not eat today as she had a cold. She had a blood glucose reading of 166 and received insulin at 5:30 p.m. She was found on the floor seizing at 9:40 p.m. It was noted her seizure was suspected from hypoglycemia. She was prescribed amoxicillin 500 mg, twice daily for 7 days (sinusitis).	**$4000.00**

	The After Visit Summary dated 12/13/24 indicated Tenant #4 was seen in the ED for a seizure from hypoglycemia and she was hypothermic upon arrival. She was given intravenous fluids (IV) and was warmed in the ED. The head computed tomography (CT) showed sinusitis and amoxicillin was ordered. It was noted to increase her threshold to 200 blood glucose for the administration of sliding scale insulin. The tenant's primary care provider (PCP) was faxed on 12/17/24 regarding the incident. Orders were confirmed by the PCP to hold Novolog if her blood glucose was 200 or below and continue amoxicillin 500 mg twice daily for the sinus infection. A new order was also received to decrease Lantus to 13 units. Further record revealed Tenant #4's diagnoses included diabetes mellitus type 1 and dementia. The service plan indicated staff administered Tenant #4's medications. Tenant #4 took insulin and had a Dexcom for monitoring her blood glucose. Staff was to monitor for signs and symptoms of hypoglycemia. 2. Review of Tenant #4's December 2024 medication administration records (MARs) indicated orders for Dexcom G6 - test blood glucose 8 times per day (continuous glucometer) scheduled at 2:00 a.m., 5:00 a.m., 8:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m., 8:00 p.m. and 11:00 p.m. She also had an order for Agamatrix - test blood glucose 8 times per day (finger stick) scheduled at the same frequency and schedule listed above. The blood glucose levels documented for 12/13/24 were as follows: - 48 at 2:00 a.m. - 205 at 5:00 a.m. - 195 at 8:00 a.m. - 181 at 11:00 a.m. - 135 at 2:00 p.m. - 161 at 5:00 p.m. Her blood sugars were not documented as taken at 8:00 p.m. as ordered. As noted above on the incident report, her levels taken at 9:45 p.m. that night when found seizing was 32. The MARs also reflected orders for Novolog Flaxen 100 units/ml solution (9 units subcutaneously every morning with breakfast, 11 units with lunch and 8 units with dinner). Staff initialed the administration of the insulin for the 7:00 a.m. to 9:00 a.m. breakfast time frame, 12:00 p.m. and 5:00 p.m. on 12/23/24. The MARs reflected an order for Novolog Flexpen 100 units/ml solution, three times per day sliding scale. Her sliding orders included the following: - if blood glucose was less than 300, then 0 units were to be administered, - for glucose readings between 300 to 350, 4 units were to be administered - for glucose readings between 351 to 400, 5 units were to be administered.	

	- the PCP was to be called for additional orders for glucose readings over 400. The December MAR reflected on 12/13/24 during the 7:00 to 9:00 a.m. time her blood glucose was 195 and staff documented sliding scale insulin was administered despite the blood glucose levels not being 300 or greater. At 12:00 p.m. her blood glucose was 181 and staff documented insulin was administered despite the blood glucose levels not being 300 or greater. Additionally, sliding scale units were administered in November, December and January and staff initialed for the administration of the medication; however, did not document the number of units of insulin administered based on the blood glucose reading, including on 12/13/24. The tenant's November, December and January MARs revealed an order to administer 1 Trueplus glucose chew 15 minutes as needed (PRN) for blood glucose readings of less than 60. In December 2024 it was documented as administered on 12/4/24, 12/6/24, 12/11/24, 12/17/24 and 12/18/24. Review of the blood glucose readings indicated Tenant #4 had blood glucose readings less than 60 on 12/2/24, 12/4/24, 12/6/24, 12/11/24, 12/13/24, 12/15/24 and 12/18/24. Glucose chews were not administered on 12/2/24, 12/13/24 or 12/15/24, despite blood glucose readings below 60. Additionally, a chew was documented as administered on 12/17/24; however, none of the recorded blood glucose readings were below 60. In January 2025 it was documented as administered once on 1/3/25. The January 2025 MARs reflected blood glucose readings less than 60 on 1/2/25, 1/3/25 (twice) and 1/5/25. Glucose tablets were not administered on 1/2/25, once on 1/3/25 and 1/5/25, despite blood glucose readings below 60. The December 2024 and January 2025 MARs also reflected an order for Gvoke Hypo 2 Injection 1 mg/0.2 ml, every day as needed for hypoglycemia. It was not documented as administered as needed in December or January. 3. When interviewed on 1/7/25 at 4:30 p.m. the Health and Wellness Director confirmed the 8:00 p.m. blood glucose check was not documented. She also confirmed all MARs and orders were provided for Tenant #4. In summary, on 12/13/24 at 9:45 p.m. staff found Tenant #4 on the floor by her bed foaming from the mouth and actively seizing. Her Dexcom indicated low and her blood glucose was 32. EMS was activated and she was taken to the ED. Per ED records she had a blood glucose reading of 46, her body temperature was 91 and she was hypothermic. She was administered D10 by EMS. She was treated with IV fluids and warmed in the ED. She was also prescribed an antibiotic for a sinusitis. It indicated in ED records she had been sick and had not eaten. Tenant #4 had ordered blood glucose monitoring eight times per day. On 12/13/24 at 5:00 p.m. her blood glucose reading was 166 and she received 8 units of insulin. On 12/13/24 at 8:00 p.m. there was no recorded blood glucose reading	

	for Tenant #4. This was the most recent scheduled blood glucose reading before she was found on the floor at 9:45 p.m. Her blood glucose monitoring was not completed as ordered. Sliding scale units were documented as administered twice on 12/13/24 despite her blood glucose readings not being greater than 300. Additionally, she had a blood glucose reading of less than 60 on 12/13/24 and several others times in December and January and the Trueplus glucose chews were not administered with blood glucose readings less than 60 as ordered. The sliding scale insulin for November, December and January reflected staff administered the insulin; however, the number of units administered was not recorded, including on 12/13/24. Tenant #4 did not receive her prescribed medications as ordered.	