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

Date: July 11, 2022
Program Name: Solon Assisted Living Village
Address: 623 E. 5th Street Solon, IA 52333
Type of Action: recertification visit
Date(s) of Action: 6/1/22 to 6/13/22
Citation # 5790

State Rule #	State Rule	Amount of Civil Penalty
67.5(2)f(4)	**481—67.5(231B,231C,231D) Medications.** **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 as ordered to 1 of 3 tenants reviewed who received medications administered by the program (Tenant #3). Findings follow: Review of Tenant #3's file on 6-8-22 and 6-9-22 revealed diagnoses included alcohol abuse, hypertension, fatty liver, COPD (chronic obstructive pulmonary disease), syncope and pulmonary nodule. The service plan reflected staff administered his medications. A Staff Communication Report dated 11-24-21 indicated staff went to give Tenant #3 a breathing treatment and he said he was not feeling well. He was nauseated and felt "flushed." Tenant #3 had a garbage can at his side. The Former Director of Nursing at the affiliated skilled nursing facility was made aware as Tenant #3 had been without medications for seven days and staff was not sure if it was related. A Staff Communication Report dated 11-25-21 indicated Tenant #3 vomited three times between 6:00 a.m. and 11:00 a.m. The reported indicated Tenant #3 was nauseated, vomited, had discomfort or pain, decreased appetite and refused a meal. At 11:00 a.m. Tenant #3's vitals indicated his blood pressure was 119/94 and his oxygen saturation was 94%. A review of hospital documents indicated the following: - A Progress Note (hospital record) indicated the tenant was admitted to the hospital on 10-12-21 for chest pain with wheezing. Tenant #3 was "in COPD exacerbation with non-STEMI type 2." He was placed on steroids, breathing treatments and antibiotics. A cardiac catheterization was completed and stent was placed to the right coronary artery (RCA). The Assessment and Plan indicated	**$2000.00**

	"Acute hypoxemic respiratory failure secondary to acute chronic obstructive pulmonary disease exacerbation." It also indicated "Non-ST segment elevation myocardial infarction type 2" and "Coronary artery disease with ejection fraction of 40% and moderate to severe septal hypokinesis, status post catheterization and stent to the RCA." - A History and Physical (hospital record) document indicated the date of service was 11-26-21. The document reflected Tenant #3 had been previously admitted on 10-9-21 with an "acute NSTEMI." He had a left heart catheterization on 10-12-21 and a stent was placed in the RCA. Tenant #3 was discharged with orders for Plavix and aspirin. On 11-26-21 when taking a shower Tenant #3 lost consciousness and did not remember anything after that. When he opened his eyes he was on the floor. 911 was called and the initial electrocardiogram showed an "inferior STEMI with complete AV block." Resident Care Notes located in the file from the SNF indicated the following: - On 10-15-21 Tenant #3 was admitted to the skilled nursing facility (SNF) level of care from the hospital. - On 11-9-21 Tenant #3 returned to the assisted living program (ALP). - On 12-2-21 Tenant #3 was admitted to the SNF level of care status post "acute inferior MI with stenting of 100% occlusion of RCA" and "3rd degree heart block with temporary pacemaker." - On 12-23-21 Tenant #3 returned to his apartment in the ALP. Continued record review revealed the October 2021 medication administration records (MARs) reflected Tenant #3 had previously taken one oral medication prior to his hospitalization which was lisinopril 20 milligram (mg) daily. Post hospitalization and SNF stay (October/November), new medications were ordered and were listed on the Home Discharge Instructions dated 11-12-21. Those orders included aspirin 81 mg daily at breakfast, Plavix 75 mg daily at breakfast, lisinopril 5 mg daily at breakfast, metoprolol succinate 25 mg daily at breakfast, pantoprozole 40 mg daily at breakfast, atorvastatin 40 mg at bedtime and budesonide 1 (vial) twice daily at breakfast and bedtime and duoneb (1 vial) four times daily. November 2021 MARs reflected 14 entries charted as medications not available from 11-12-21 to 11-25-21. The entries on 11-12-21, 11-20-21, 11-21-21, 11-22-21, 11-23-21 and 11-25-21 indicated there were no a.m. medications available. The medication at bedtime, atorvastatin was charted as not available on 11-19-21, 11-20-21 and 11-21-21. Review of the Nurse's/Care Notes did not reflect any documented entries related to the medication availability issue in November 2021. The Home Discharge instructions dated 11-12-21 were not noted with time, date or signature when the orders were received. A medication error report was not completed related to medications not being available to administer to Tenant #3 during November 2021. When interviewed on 6-13-22 at 12:52 p.m. the AL Manager said the medication (atorvastatin) could not be filled until Tenant #3 was seen	

	by his cardiologist in the office. He said he could not speak to the a.m. medications and why they were not administered. Program documents revealed there was no program nurse from September 2021 to December 2021. When interviewed on 6-29-22 at 1:48 p.m. Tenant #3's primary care provider could not recall if he had been notified of the medications not administered but if he had it should have been documented in the program's records. When asked about Tenant#3's medications not administered for greater than five days and any possible correlation to his hospitalization (November 2021) he would not provide a comment or opinion but said it was "not ideal." In summary, Tenant #3 was prescribed one oral medication in October 2021 and staff assisted with medication administration. On 10-9-21 Tenant #3 went to the hospital, was admitted and went to SNF before he returned to the program on 11-9-21. There were new orders for medications upon discharge from SNF and return to the program. Tenant #3 did not receive the medications as prescribed and the medications were documented as not available. There were multiple entries regarding medications not available from 11-12-21 to 11-25-21, including all of his morning medications. Per staff communication records Tenant #3 was nauseated, vomiting and did not feel well on 11-24-21 and 11-25-21. Tenant #3 was sent out to the hospital on 11-26-21 after he lost consciousness. Tenant #3 was admitted to the hospital again on 11-26-21 and then was discharged to SNF s/p "acute inferior MI with stenting of 100% occlusion of RCA." Tenant #3 returned to the Program on 12-23-21. Tenant #3 did not received the medications as prescribed in November 2021.	