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

Date: April 19, 2024
Program Name: Stirlingshire of Coralville AL
Address: 1140 Kennedy Parkway Coralville, IA 52241
Type of Action: 113475-C
Date(s) of Action: 3/4/24 – 3/7/24
Citation #: 10313

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. Based on interview and record review the program failed to ensure 1 of 1 tenants reviewed who was hospitalized for a drug overdose received adequate care, treatment and services (Tenant #1). Findings follow: On 3/4/24 review of an incident report dated 2/23/24 at 7:15 PM identified Staff A went to Tenant #1's apartment to pass medication. Tenant #1 was laying in bed and Staff A called out to her. Staff A shook Tenant #1 several times but received no response. Tenant #1 was breathing but not waking up. Staff A called the nurse, explained the situation and was directed to call 911. Tenant #1 went to the emergency room. The DON (Director of Nursing) documented in the progress notes she received a call from the hospital social worker on 2/29/24 letting them know they were preparing to discharge Tenant #1. The social worker wanted the DON to know Tenant #1 had overdosed unintentionally on Tylenol PM. The program received an order from Tenant #1's primary care provider (PCP) on 11/7/23 for Tenant #1 to use Narcan as needed due to opiate usage. The Centers for Disease Control listed Narcan as a life-saving medication which could reverse an overdose from opioids, including prescription opioid medications. Tenant #1 was prescribed an opioid medication, Morphine. The directions on the use of Narcan included to use 1 spray into one nostril once as needed. Repeat with a second device into the other nostril after 2-3 minutes if no or minimal response. On 3/6/24 at 3:30 PM Staff A recalled she went to give Tenant #1 her bedtime medication on 2/23/24. Staff A always called out to let Tenant #1 know when she entered the apartment, but that night Tenant #1 didn't answer. When Staff A spoke to Tenant #1 she did not receive a response so she shook her again. Tenant #1 was laying on her bed in a position which did not appear comfortable. Staff A called the DON who instructed her to call 911. After the Emergency Technician's (EMTs) arrived, Staff B entered the apartment and told them Tenant	**$5000.00**

	#1 had Narcan. Staff B said give her Narcan and the EMTs administered this twice. Tenant #1 woke up after the second dose. Staff A reported she knew Tenant #1 had Narcan at one time because she was delegated on how to use the medication by the previous DON. The previous DON told them how to administer Narcan if Tenant #1 ever needed it. When Tenant #1 was initially administered Narcan, it was stored in the medication cart with the narcotics. When the current DON was hired, the Narcan was no longer stored in the medication cart, so she thought Tenant #1 did not use Narcan any longer. On 4/3/24 at 9:56 AM Staff B reported she was working on the memory care unit when she heard the ambulance sirens. Usually the EMTs turn the sirens off when they get close to the building but they did not do so that day so she knew something was really wrong. Staff B went to the front desk and Staff A informed her Tenant #1 was non-responsive. Staff B informed Staff A Tenant #1 had Narcan. When Staff B was first trained on how to use Narcan she recalled the medication was stored in an orange box. She thought the previous DON showed her how to administer Narcan to a tenant. Staff B was a medication aide, so she knew Tenant #1 was prescribed Narcan. When she got to Tenant #1's apartment, she told the paramedics the tenant needed Narcan. She and Staff A looked through the medication box but couldn't find the Narcan right away because she was looking for an orange box and now Tenant #1's box of Narcan was white. The paramedics said they had their own supply and administered it. Staff B was not delegated on the use of Narcan by the current DON. On 3/5/24 at 10:04 AM, the DON reported she had contacted the PCP about the order for Narcan as no other tenants at the program were prescribed Narcan. According to the DON, the PCP prescribed the Narcan as Tenant #1 received Morphine. The DON reported she talked with staff about Tenant #1 taking Narcan but had no documentation about this. The DON considered the use of Narcan to be similar to other nasal sprays and staff were delegated about the use of nasal sprays. The DON instructed newly hired staff (since 11/7/23) Narcan was a medication a tenant had and how it should be used. On 4/3/24 at 9:43 AM, the DON reported on 2/23/24 she could did not recall Tenant #1 used Narcan which was why she did not instruct Staff A to administer it. The DON told staff to administer a sternal rub. If one of the staff members told her Tenant #1 had Narcan, she would have told them to administer it. The DON confirmed it would have been important for staff to know Tenant #1 had Narcan available. On 2/23/24, staff had not been trained by her on how/when to use Narcan. A review of progress revealed the DON spoke with Tenant #1's sister following the incident on 2/23/24 about medication bottles found in Tenant #1's apartment which were not prescribed. The DON noted there were a large number of medications, too many to count. There were bottles of Tylenol, Excedrin, Excedrin Migraine, Nyquil and a lot of medications with no markings on them in cups and bottles. The	

	guardian was going to remove the pills on that date. As of 3/4/24, staff had not returned to the apartment to determine if it was a safe place to which the tenant could return. On 3/4/24 at 3:30 PM, Staff A reported she had not ever seen pill bottles in Tenant #1's apartment. However, the tenant received many packages from Amazon. She could hear the pills rattle when she delivered them to the apartment. Tenant #1 had a private caregiver. The first caregiver Tenant #1 employed quit because she was reportedly afraid she would enter the apartment and find Tenant #1 dead from a medication overdose. On 3/4/24 at 2:05 PM, Staff C reported she had not seen bottles of medication in Tenant #1's apartment, but in the past Tenant #1 ordered a lot of medication. The Executive Director and DON were aware of this. On 3/4/24 at 2:20 PM the DON stated Tenant #1 had a habit of ordering medication off Amazon. After Tenant #1 went to the hospital, they found over-the-counter drugs in an open drawer in the apartment. The DON called Tenant #1's sister and asked for permission to go in the apartment and look for medication. The DON and another staff member opened drawers and there were 2 drawers full of Tylenol, Tylenol PM, Excedrin, Pepto-Bismol, mouth wash and Afrin nose spray. They then opened the secretary which was also packed full of medication. There were med cups in the secretary with some sort of medication in them. Tenant #1's sister agreed to remove the medication for her sister's safety. The sister took out 2 garbage bags of medication. The hospital social worker told the DON Tenant #1 unintentionally overdosed on Tylenol PM. A review of Tenant #1's hospital discharge summary noted her principal problem at the time of admission was drug overdose of undetermined intent, initial encounter. Over the course of Tenant #1's stay in the hospital, she experienced urinary retention and needed intermittent catheterization. Her doctor believed this was due to Benadryl use which was discontinued. Tenant #1 returned to the program on 3/5/24. On 3/5/24 at 9:30 AM the DON confirmed she was not aware of the number of medications or what type of medication Tenant #1 was taking.	