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

Date: April 28, 2023
Program Name: Holland Farms
Address: 2800 Sunset Drive Norwalk, IA 50211
Type of Action: Complaints #111304-C
Date(s) of Action: 2/28/23 – 3/3/23
Citation #: 6090

State Rule #	State Rule	Amount of Civil Penalty
IAC 481-67.5(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 according to physician's orders. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follows: Record review of Tenant #1's file on 3/1/23 revealed the following: Discharge instructions for hospital stay from 1/1/23 to 1/6/23 revealed weakness, shortness of breath, hemoglobin of 6.5 and required admission for blood transfusion. Diagnoses included iron deficiency, anemia, chronic atrial fibrillation, chronic renal insufficiency, hypertension, hypothyroidism, and congestive heart failure. His International Normalized Ratio (INR) was 8 upon admission and 4.6 on 1/5/23 (normal range 2.0 to 3.0 for patients routinely anticoagulant). Further review noted to follow up with the primary physician within one week and follow up with cardiology and hematology as scheduled. Discharged medications revealed no order for warfarin and the discharge face sheet noted to stop taking warfarin. Discharge instructions for hospital stay from 2/2/23 to 2/3/23 noted he was admitted for weakness and falls. Further review revealed the hospital put warfarin on hold with his INR level at 11.2 upon admission and Tenant #1's level was 2.0 when discharged. The physician noted Tenant #1 required a follow up with him in one week, follow up with hematology as scheduled, and required an appointment with cardiology in one month to discuss if anticoagulation should be restarted. Review of Medication Administration Records (MAR) revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday,	**$5000.00**

	Thursday, and Saturday during the month of January 2023. Further review revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday from 2/4/23 to 2/18/23. The staff noted the warfarin was discontinued per nurse on 2/27/23. When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse (RN) stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. On 3/2/23 at 2:50 p.m. the RN reported if a person had an INR of 11 and suffered an injury that caused bleeding, they would be a critical risk of major bleeding and possible death if not found right away. **69.25(1) Documentation for each tenant shall be maintained by the program and shall include:** **i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception** Based on interview and record review the Program failed to obtain discharge instructions when a tenant returned from the hospital. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follows: See concerns cited at Iowa Administrative Code (IAC) 481 - Chapter 69.26(4)a for additional information. Record review on 3/1/23 revealed Tenant #1's Medication Administration Records (MAR) revealed staff administered warfarin from 2/4/23 to 2/18/23. Additional record review revealed Tenant #1's service plan dated 3/1/23 documented Tenant #1 took warfarin. Record review of Tenant #1's file on 3/1/23 revealed Tenant #1's discharge instructions from his hospital stay on 1/1/23 to 1/6/23. Tenant #1's physician discharge instructions included discontinuation of the medication warfarin. Continued record review revealed Tenant #1's discharge instructions from his hospital stay from 2/2/23 to 2/3/23. The instructions noted the hospital put Tenant #1's warfarin on hold upon his admission to the hospital. The instructions further directed	

	Tenant #1 scheduled an appointment with cardiology in one month to discuss if an anticoagulation should be restarted. When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse (RN) stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin in January 2023. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. When interviewed on 3/2/23 at 2:50 p.m. the RN reported if a person had an INR of 11 and suffered an injury that caused bleeding, they would be a critical risk of major bleeding and possible death if not found right away. **69.26(4) The service plan shall be individualized and shall indicate, at a minimum:** **a. The tenant's identified needs and preferences for assistance** Based on interview and record review the Program failed to update service plans as warranted.. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follows: Record review of Tenant #1's file on 3/1/23 revealed the following: Discharge instructions for hospital stay from 1/1/23 to 1/6/23 revealed weakness, shortness of breath, hemoglobin of 6.5 and required admission for blood transfusion. Diagnoses included iron deficiency, anemia, chronic atrial fibrillation, chronic renal insufficiency, hypertension, hypothyroidism, and congestive heart failure. His International Normalized Ratio (INR) was 8 upon admission and 4.6 on 1/5/23 (normal range 2.0 to 3.0 for patients routinely taking an anticoagulant). Further review noted to follow up with the primary physician within one week and follow up with cardiology and hematology as scheduled. Discharged medications revealed no order for warfarin and the discharge face sheet noted to stop taking warfarin. Health and Functional Assessment dated 1/9/23 noted he returned from the hospital with no change in level of care. Continued review revealed the nurse documented he received anticoagulation therapy. The service plan failed to be updated to reflect the warfarin was discontinued. Discharge instructions for Tenant #1's hospital stay from 2/2/23 to 2/3/23 noted he was admitted for weakness and falls. Further review revealed the hospital put warfarin on hold with his INR level	

	at 11.2 upon admission and his level was 2.0 when discharged. The physician noted Tenant #1 required a follow up with him in one week, follow up with hematology as scheduled, and required an appointment with cardiology in one month to discuss if anticoagulation should be restarted. Health and Functional Assessment dated 2/7/23 noted he received anticoagulation therapy. The service plan failed to be updated to reflect the warfarin was discontinued. Review of Medication Administration Records (MAR) revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday during the month of January 2023. Further review revealed Program staff administered 2.5 milligrams (mg) of warfarin every Monday, Wednesday, and Friday and 5 mg every Sunday, Tuesday, Thursday, and Saturday from 2/4/23 to 2/18/23. The staff noted the warfarin was discontinued per nurse on 2/27/23. When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. **69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse:** **b. To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program** Based on interview and record review the Program failed to complete a nurse review as warranted by a significant change in condition. This pertained to 1 of 1 tenants reviewed with medication changes after a hospital admission (Tenant #1). Finding follow: Record review on 3/1/23 revealed Tenant #1's discharge instructions from his hospital stay from 2/2/23 to 2/3/23. The instructions noted the hospital put Tenant #1's warfarin on hold upon his admission to the hospital. The instructions further directed Tenant #1 scheduled an appointment with cardiology in one month to discuss if an anticoagulation should be restarted.	

	Continued record review revealed Tenant #1's Medication Administration Records (MAR) revealed staff administered warfarin from 2/4/23 to 2/18/23. Additional record review revealed Tenant #1's service plan dated 3/1/23 documented Tenant #1 took warfarin. Continued record review of Tenant #1's file failed to reveal a nursing review of Tenant #1's discharge orders from his hospital stay on 2/2/23 to 2/3/23. Cross-reference: Iowa Administrative Code (IAC) 481 - Chapter 69.26(4)a When interviewed on 3/1/23 at 1:55 p.m. the Registered Nurse stated discharge instructions are reviewed when a tenant returned from the hospital. She said she did not know why she overlooked the information related to discontinuing the warfarin. She confirmed she completed a change of condition on 1/9/23, 2/7/23, and 2/26/23 and noted he continued to take warfarin on the assessments and service plans. She confirmed she never received the discharge orders from 2/3/23 and failed to obtain them for review. When interviewed on 3/2/23 at 2:50 p.m. the RN reported if a person had an INR of 11 and suffered an injury that caused bleeding, they would be a critical risk of major bleeding and possible death if not found right away.	

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