Iowa Department of Inspections and Appeals
Assisted Living Program
Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 7965**

Cathy Morel
Amber Ridge
107 E 2nd Street
DeWitt, IA 52742

Date of Investigation:

September 9, 2004

Monitor(s):

Stephanie Cummins, SW

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Amber Ridge on September 9, 2004. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP) **– A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.**

Current number of tenants without cognitive disorder:	19
Current number of tenants with cognitive disorder:	0
Total General Population:	19

Dementia Specific Program (DSP) **–** Not applicable**.**

Accreditation Status – Not applicable.

Complaint History – During this certification period there were substantiated complaints in the area of Medications**.**

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

Complaint Allegation: It was alleged the program did not appropriately assess a tenant after a fall occurred.

- Monitoring Observation: Tenant #1 fell in the tenant's apartment on 7/13/04 and was found by A staff member at 6:00 a.m.. At 6:05 a.m. Staff Member #1 called the RN and reported the fall and described the tenant's legs as 'looking funny'. The RN told Staff Member #1 to call the ambulance. The RN arrived at the program before the ambulance. and stated the ambulance took approximately 15 minutes to arrive. According to the RN, the tenant's vitals were taken prior to the arrival of the ambulance. The admission documents from DeWitt Community Hospital stated the tenant arrived by ambulance at 7:30 a.m.. The RN stated she called the Administrator to inform her of the fall and also stated the Administrator went to the hospital that morning to see the tenant. The RN stated in an interview that two-hour checks through the night were provided for the tenant and stated this tenant had a long history of sleeping through the night. Interviews with direct care staff indicated they knew what to do when a tenant experienced a fall. The staff also stated the RN and the Administrator were available when needed and responded in a prompt manner.

- Regulatory Insufficiency: None noted.

B. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [321 IAC 25.29(1) and/or (2)]

Complaint Allegation: It was alleged the program did not provide appropriately supervised medications.

- Monitoring Observation: Four of the 19 tenants at the program self-administered medications. According to staff, there were times when tenants did not have the medications that were required. According to the RN and the Administrator, there had been problems with refilling medications for Tenant #2, due to a government insurance plan. The RN stated that Tenant #2's insurance company would not accept refills more than two days prior to being out of the medications. According to the RN, the program had recently addressed this issue by asking the tenant's physician for samples for the interim. Tenant #3 had also experienced delay in getting medications, according to the RN. Tenant #3 was a Hospice patient and a delay occurred because the medications required approval by the Hospice RN and were brought by courier from Davenport, according to the RN. According to staff interviews, Tenant #3 was no longer a Hospice patient as of 9/8/04. The RN also indicated in an interview that there were times when the pharmacy was out of medications and issued a slip that indicated what pills were still owed to the tenants. The RN and the Administrator stated the pharmacy often delivered medications in the early evening after the RN had left the program. The medications delivered were placed in the RN's office. All staff members had access to the RN's office. The RN's office was left unlocked and the medications were placed in

the office along with extra bottles of medications, over the counter medications, and first aid supplies. These medications were kept in unlocked containers. According to the RN, the narcotics were locked in a cupboard and then locked up again inside the cupboard. The office was left unlocked for the convenience of direct care staff, according to the RN.

On 8/13/04, Staff Member #4 received the medications delivered from the pharmacy and put the medications in the RN's office. Staff Member #5 worked the first shift on 8/14/04 and 8/15/04. Tenant #3 had orders for 120 mg. of Cardizem at 8:00 a.m. and 2:00 p.m.. According to an incident report, Tenant #3 was not given Cardizem at 8:00 a.m. and 2:00 p.m. on 8/14/04 as prescribed, and was not given the 8:00 a.m. dose on 8/15/04 and the 2:00 p.m. dose was given late on 8/15/04. Staff member #4 stated Staff Member #5 reported to Staff Member #4 on 8/15/04 at the shift change that the Cardizem was not given to this tenant because the medication was not in the med planner. According to the incident report, Staff Member #6 checked the office for the medication and was unable to locate this medication. The medication was delivered after hours on 8/13/04 and put in the RN's office. The medication was listed differently on the medication and on the MAR, which according to Staff Member #5 caused confusion in locating the medication in the office. The MAR had the generic name for the medication with Cardizem listed below it in red to note the non-generic name. Staff Member #5 did not report this incident to the RN. All staff members interviewed, stated the procedure to be followed, if medications were not in a planner, was to check the RN's office for refill medications and then to call the RN if there were any questions or if the medications could not be found. Staff Member #4 notified the RN of the situation that occurred. The tenant received the 2:00 p.m. dose of Cardizem at approximately 3:30 p.m.. The MAR had "white-out" on the 8:00 a.m. dose and 2:00 p.m. dose on 8/14/04, with circles in the boxes and also had "white-out" on the 8:00 a.m. dose on 8/15/04 with an empty circle in the box. The 2:00 p.m. dose had "white-out" on it as well, however it had the initials of a staff member over the "white-out."

Tenant #4 had orders for blood sugars to be taken and Humulin given at 8:00 a.m. and at 5:00 p.m.. Both orders were issued in the year 2002 and according to staff interviews, this tenant had never received a 12:00 p.m. blood sugar and insulin. According to Staff Member #4 and an incident report, Staff Member #5 verbally reported to Staff member #4 on 8/15/04 at shift change, that a potential error had occurred with Tenant #4's medications. Staff Member #5 stated that 20 units of insulin had been given to this tenant at 12:00 p.m.. Staff Member #5 stated the tenant had also received the 8:00 a.m. dose of insulin. Staff Member #6 gave the 8:00 a.m. dose because Staff Member #5 was too busy and overwhelmed, according to program records. Staff Member #5 signed off on the flow sheet that the blood sugar was taken and that 20 units of insulin were given at 11:30 a.m.. Staff Member #4 notified the RN of the incident and staff took the tenant's blood sugar. The tenant's blood sugar had recovered by the end of the day and the tenant suffered no adverse reactions. The staff observed the tenant for the entire day and communicated with the RN throughout the day regarding the tenant's condition. Tenant #4 had a large pink instruction sheet on top of the clipboard that held the MAR and flow sheets in the tenant's apartment. The pink slip contained the times insulin was to be given and the slip also provided instructions. The RN asked Staff Member #5 why the staff member had not called to report the incident and Staff Member #5 stated "I didn't think it was a big deal," according to program records. On 8/16/04, an inter-office memo showed three other medication errors made by Staff Member #5. The errors all occurred on 8/15/04. One tenant did not get any pills on 8/15/04 at 8:00 a.m.. Another tenant did not get ear

drops on 8/15/04 at 8:00 a.m.. A third tenant did not get pain medication at 12:00 p.m. on 8/15/04.

In May of 2004, Staff Member #5 was administering medications to Tenant #2 in the tenant's apartment. According to an interview with the RN, Staff Member #5 found a medication error while in the tenant's apartment and proceeded to call the RN with questions, from the tenant's apartment. The family member of Tenant #2 was in the apartment when Staff Member #5 called the RN. Staff Member #5 had indicated the family member would help correct the error, but the RN did not want to create further medication errors by having another person involved and asked Staff Member #5 to take the med planner to the office to determine the med error.

On 8/15/04, Staff Member #5 wrote the RN a letter, which addressed concerns Staff Member #5 had with medications. The staff member stated that Tenant #4 had orders for insulin at 12:00 p.m. the last time the staff member worked that shift. Staff Member #5 also stated that noted changes in medications should be left for all to see. Interviews with staff and review of the MAR indicated the tenant's orders for Humulin at 8:00 a.m. and 5:00 p.m. began in the year 2002. Staff also indicated this tenant had never required a dose of Humulin at 12:00 p.m.. On 4/8/04, the RN asked Staff Member #5 to write down anything the staff member was uncomfortable with at work and Staff Member #5 wrote down "I cannot think of a thing."

On 8/20/04 Staff Member #5 was terminated via mail. Staff Member #5 wrote letters to the Administrator and the management of the program. Staff Member #5came into the program on 8/27/04 and a staff member thought Staff Member #5 was visiting with some of the tenants during an activity. Staff Member #5 had dropped off letters to some of the tenants at the program. The letter to the tenants included a copy of the termination letter issued by the RN to Staff Member #5 and a personal letter that discussed medication errors that occurred at the program. According to program records, a family member of a tenant had also received a letter sent by Staff Member #5, mailed to the family member's home.

A complaint investigation occurred at the program May 20, 2004. A Regulatory Insufficiency was given for medications due to numerous medication errors including medications not being set up correctly at the program. The plan of correction for the program was dated 6/24/04 and it stated that the RN would continue to set up the medications in a quiet environment to avoid disruptions. Then the LPN or the CMA performed a cross check to see if any errors had occurred. If errors had occurred, they were recorded in a log. If errors continued, the Administrator was to make a report to the management of the program. According to staff interviews the number of medication errors had decreased significantly since developing this system. From 5/25/04 to 9/8/04, with the RN setting up medications and the other staff cross-checking, there were 27 medication errors caught by the cross-checking staff according to the medication error log kept by staff.

- Regulatory Insufficiency: The program did not ensure medication administration was appropriately supervised and administered by the program nurse in accordance with 655–subrule 6.2(5) and 6.3(1), Iowa Code chapter 155A and IAC 321–25.29(2) including training and storage.

C. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: It was alleged the program did not have appropriately trained staff administering medications.

- Monitoring Observation: An interview with the RN indicated all current staff have passed the medication course taught by the RN with the exception of the two newest hires who were in the process of taking the course. The course had seven chapters covering the following issues: The Caregiver's Role In Medication Assistance, Monitoring Resident Health and Medication Use, Preparing to Assist with Medications, Assisting with Medications, Assisting with the Diabetic Resident, Reporting Medication Assistance, Medication Storage, Disposal, and Inventory. Each staff member was given a text binder to reference and to prepare for the final exam, according to the RN. Staff Member #5 was hired 1/6/04 and had not successfully completed the entire medication course at the time of termination. The program had documentation of 10 sessions/courses regarding medications. Staff Member #5 had attended all of these sessions. Staff Member #5 took the final exam of the medication courses after two sessions and did not receive a passing score. The staff member then proceeded to attend the remainder of the medication courses offered by the program. Additionally, all staff members were given several handouts regarding diabetes and the elderly. According to the RN, all staff were oriented on passing medications by the RN, but no documentation of this initial orientation could be provided. The program is currently using a Nursing Delegation Flow Sheet to show what each staff member has been delegated. Staff interviews indicated the RN provided some initial training and then the new hires followed and observed the experienced direct care staff; the experienced direct care staff then followed and observed the new hires. According to staff interviews, direct care staff were not always certain what training the RN had already provided to new employees.

- Regulatory Insufficiency: The program did not provide for appropriate medication training via Nurse Delegation, which includes practicum checks by the nurse, [Code chapter 152 and 655–Chapter 6], not peer to peer.

- Regulatory Insufficiency: The program did not have documentation of training received by staff members.

Dated this 6th day of October 2004.