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

Assisted Living Program: **Complaint Intake #: 8011**

Kirk Erickson
Rosebush Gardens
4925 West Avenue
Burlington, IA 52601

Date of Investigation:

October 28, 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 Rosebush Gardens on October 28, 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:	33
Current number of tenants with cognitive disorder:	6
Total Population:	39

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

Accreditation Status –Not applicable.

Complaint History – There were no substantiated complaints during this certification period.

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

A. 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 staff at the program could not account for tenants' narcotic medications.

- Monitoring Observation: Staff Member #1 was hired on 1-7-02 and was terminated on 10-22-04 due to a medication error that involved this staff member giving a personal medication to a tenant at the program. A criminal background check was done prior to hire.

  On 2-10-03, this staff member called into the program to report an inability to return to work because the staff member had been drinking since the previous week. This staff member continued to call in from 2-4-03 through 2-7-03 and was scheduled to work on 2-10-03. According to program records, this was the second period of time this staff member could not come to work due to drinking. On 2-12-03 a contract was drawn up between the Administrator and this staff member that stated the staff member must attend AA meetings and remain sober in order to work as scheduled and never to work under the influence. There was an incident report, dated 9-11-03, in the employee file that stated the staff member had signed off for giving a medication two nights in a row when the cassette had been pulled and sent back by mistake.

  A Worker's Compensation note dated 9-9-04 stated this staff member sustained a sacral contusion five weeks prior when she fell and on 9-6-04 ran into the corner of a metal table right at the spot of the sacral contusion, which caused an increase in pain. A repeat X-ray was negative. This staff member was given Percocet every four to six hours with a plan to scale back to Ultram on a PRN basis. On 9-10-04, the Administrator received a call from the staff member's physician's nurse indicating the physician gave this staff member a prescription for Percocet for pain. Staff Member #1 told the physician this staff member would be going to California and requested more Percocet and the physician gave this staff member more Percocet. The Administrator reported this staff member never went to California and this was documented by the staff member's time sheets.

  Research done by the Administrator showed there were five tenants that received program administered PRN medications. The information was broken down by how many PRN medications were given on each shift and by which staff member. The PRN medications included: Tylenol #3, Darvocet, Percocet, and Hydrocodone. Of the PRN medications given, 12 were given on first shift, two on third shift, and 562 on second shift. Program records reviewed noted Staff Member #1 worked on second shift and gave 83.8% of the PRN medications given at the program. These figures were primarily drawn from September 2004 but did include information from May 2004 on two tenants and August 2004 on one tenant. Tenant #1 had a diagnosis of spinal stenosis, acute gastritis, CAD, HTN, and dementia. Tenant #1 had program-administered medications, but had since transferred from the program. The tenant

received Percocet (endocet) 1-2 PO Q6H PRN for pain. According to research completed by the Administrator from 1-14-04 to 6-30-04, there were 21 Percocet tablets unaccounted for and of those, 20 occurred on Staff Member #1's shift.

Tenant #2 had a diagnosis of HTN, Angina, and borderline Diabetes. Tenant #2 was independent for medication administration. In early August 2004, this tenant had leg pain due to a blood clot and was started on Hydrocodone. The tenant had leg surgery to remove the blood clot on 8-26-04. This tenant was no longer on this medication. According to the Administrator, RN, and the tenant, receipts from 8-6-04 to 8-14-04 200 Hydrocodone tablets were ordered and filled for Tenant #2. These prescriptions were filled from at least two different pharmacies. The prescription read "take one tablet every four hours as needed." If the tenant had taken one tablet every four hours, 24 hours a day for those nine days, 54 tablets would have been taken. The tenant approached the RN in mid August and stated the tenant was in pain and needed more pain medication. The RN called the tenant's physician and the physician's office would not give a prescription for more Hydrocodone. At that time the tenant had five of the 200 Hydrocodone tablets that were ordered, which left 146 tablets of Hydrocodone unaccounted for. According to the RN, the tenant showed no signs of an overdose during that time period. The RN and Administrator approached the tenant after Staff Member #1 was terminated on 10-22-04. It was at that time they asked the tenant if they could review the tenant's receipts for medications and found how many tablets had been ordered. According to the tenant, Staff Member #1 also picked up this tenant's medications a few times. James Ruberg from the Burlington Police Department found that Staff Member #1 had signed for one of the prescriptions for 60 Hydrocodone tablets at Walmart's Pharmacy. The program had issues of potential narcotic theft in the past.

Tenant #3 fell, which resulted in a hairline fracture of the right humerous and was given (Hydrocodone) Vicodin for pain. According to program records, the order was placed on 3-3-03 and the tenant was given two Vicodin on 3-4-03. Later that morning the tenant went back to hospital due to decline in condition. The tenant had only received two Vicodin before re-entering the hospital. On 3-10-03, it was discovered that six Vicodin were unaccounted for.

In November of 2003, it was discovered by the RN and the pharmacist that Acetaminophen/Tylenol was placed in the cassettes instead of the pain medications that were supposed to be in the cassettes. Hydrocodone, Acetaminophen with codine, and Oxycodone were the pain medications that were missing. After this discrepancy was discovered, the program had all controlled medications converted from cassettes to bubble packs. The program also had a Urinary Analysis done on all PCA's, RN, and the Administrator; all staff members passed the test. The controlled medications were locked in a cupboard in the RN's office. According to staff interviews, one Personal Care Assistant (PCA) had the key on each shift. It was usually the shift supervisor that held the key to the controlled medications. Staff Member #1 was a second shift supervisor at the program prior to the staff member's termination. According to staff interviews and review of program records, at the beginning of each shift the outgoing PCA and oncoming PCA counted controlled medications and deducted what medications had been used during the shift. The RN stated the MARs and the counts sheets were checked separately prior to July 2004. After July 2004, during each shift change when counting narcotics, the counts sheets were cross-

checked with the PRN sheets to confirm when a pill was given it was recorded in both areas. In interviews with direct care staff, a competency test for medication management was given to all staff members by the RN. Additionally, quarterly reviews of staff competency of medication passes were completed on all staff members. Staff interviews confirmed staff members did not pass medications until they were comfortable and competent passing medications. None of the staff members that were interviewed had any questions or concerns regarding medication administration and indicated they felt comfortable passing medications at the program. The direct-care staff stated the medication administration training they received was sufficient. In addition to a competency test and quarterly reviews, the program held numerous staff in-services regarding appropriate medication administration procedures.

- Regulatory Insufficiency: The program did not count narcotic medications according to accepted medication protocol.

- Regulatory Insufficiency: The program did not delegate medication administration to Staff Member #1 appropriately.

- Regulatory Insufficiency: The program cannot account for missing narcotics.

Dated this 1st day of December 2004.