IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

DEAN A. LERNER, DIRECTOR

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

June 25, 2008

Complaint #18079

Ms. Jill Maxwell, Administrator
Eiler House Assisted Living
920 West Garfield
Clarinda, IA 51632

RE: Complaint Investigation Report, Eiler House Assisted Living, Clarinda, IA

Dear Ms. Maxwell:

Enclosed is the **Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

If you have questions, please contact me at 515-281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
Lead Certification Coordinator – Western Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint Intake #:** 18079

Ms. Jill Maxwell, Administrator
Eiler House Assisted Living
920 West Garfield
Clarinda, IA 51632

Date of Investigation:

June 17, 2008

Monitor(s):

Hal L. Chase, RN BSN MPH

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 revisit 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 Eiler House Assisted Living on June 17, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants without cognitive disorder:	28
Current number of tenants in a DSP that serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	8
Total Population:	36

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There were substantiated complaints in the areas of Service Plan and Staffing during this certification period.

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

A. 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 is alleged medications have been stolen and staff comes to work "high on marijuana and smoke marijuana while on the job."

- Monitoring Observation: Tenant #1 is an 84 year old, admitted on 8-15-06 and has diagnoses of: Osteoarthritis, Atrial Fibrillation, History of Deep Vein Thrombosis, Degenerative Disc Disease and a History of Right Knee Replacement. The service plan of 5-1-08 indicated the tenant self administers his/her own medications.

  Tenant #2 is a 92 year old, admitted on 7-31-06 and has diagnoses of: Osteoporosis, Macular Degeneration, Hypotension, Depression, Anxiety and Peripheral Neuropathy. The service plan of 4-23-08 indicated the tenant self administers his/her own medications.

  Staff #1 stated Tenant #1 had ten to twelve Hydrocodone missing out of a bottle of thirty tablets about two months ago and Tenant #2 had Hydrocodone missing about two and half months ago. Staff #1 stated the program contacted the regional Registered Nurse (RN), notified the police and interviewed staff about the missing medications. Staff #1 stated there were no other medications missing from tenants who self administer or are administered medications by the program. Staff #1 stated she did not know of any staff working under the influence of drugs or alcohol.

  Staff #2 stated Tenant #1 had an unknown amount of Hydrocodone missing from a bottle kept in the tenant's apartment about the end of April 2008, and Tenant #2 had missing Hydrocodone two weeks earlier. Staff #2 stated she didn't know if the medications were stolen. Staff #2 stated she did not know of any staff working under the influence of drugs or alcohol.

  Staff #3 stated Tenant #1 had 25 tablets missing out of 180 tablets of Hydrocodone around the end of April 2008. Staff #3 stated Tenant #2 had an unknown amount of Hydrocodone missing about four months earlier. The Regional RN was called in both cases. Staff were interviewed and a staff meeting was held to discuss the missing medications. Staff #3 stated she did not know of any staff working under the influence of drugs or alcohol.

  The RN stated Tenant #1 advised staff about four months ago he/she was missing several Hydrocodone from a new pill bottle. The tenant called the local pharmacy and the pharmacist told him/her it was possible they did not fill the prescription correctly, but probably not that many pills would be missing. Staff instructed the tenant to lock his/her medications and there has been no further problems with missing medications. The RN stated Tenant #2's son advised staff a couple of weeks earlier two Hydrocodone were missing from a "med set." The tenant's son stated it was possible he/she could have dropped them due to poor eyesight. Staff instructed the tenant to put the medications in a locked drawer and there has not been any medications missing.

The Administrator stated Tenant #1 informed her that 25 tablets of Hydrocodone were missing from a brand new bottle. The tenant was instructed to lock medications in a drawer. The Administrator stated a camera was installed in the tenant's apartment but this was unsuccessful. Two to three weeks later the tenant had more missing medications. The Administrator stated the medications "always came up missing during one employee's shift. This employee's hours have been cut and "nothing has come up missing since."

The Administrator and RN stated they did not know of any staff working under the influence of drugs or alcohol. The Administrator stated drug testing had not been done "because corporate won't authorize drug testing."

A review of employee and tenant incident reports for the past four months did not indicate any accidents or injuries to tenants, inappropriate behavior on the part of staff, or medication incident reports of missing medications. A review of current Medication Administration Records (MARs) indicated medications were administered appropriately.

- Regulatory Insufficiency: None noted.

Dated this 24th day of June 2008.