IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

August 13, 2008

Incident #18201-I

Ms. Linda Strubbe, Director
Fieldcrest Assisted Living
2501 East 6th Street
Sheldon, IA 51201

RE: Incident Investigation Report, Fieldcrest Assisted Living, Sheldon, IA

Dear Ms. Strubbe:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Incident Investigation Report dated August 9, 2008. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary. The Final report is enclosed.

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-5721.

Sincerely,

Tamara Halvorson

Tamara Halvorson
Lead Certification Coordinator – Western Iowa
Adult Services Bureau

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

Assisted Living Program: **Incident Intake #: 18201-I**

Linda Strubbe, Administrator
Fieldcrest Assisted Living
2501 East 6th Street
Sheldon, Iowa 51201

Date of Investigation:

July 7, 8 and 9, 2008

Monitor(s):

Michael Streepy, RN

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 Incident 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:

An on-site visit was conducted at Fieldcrest Assisted Living on July 7, 8 and 9, 2008. 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:	57
Current number of tenants with cognitive disorder:	2
Total Population:	59

Dementia Specific Program (DSP) – Not applicable.

***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 regulatory insufficiencies in the areas of: Service Plan, Nurse Review, Food Service, Staffing and Record Checks during this certification period.

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

A. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

During the course of the investigation the following information was obtained:

- Monitoring Observation: Tenant #2, a 63 year old, had been admitted to the program 05-17-05 with diagnoses including: Diabetes, Depression, Hypertension, Chronic Obstructive Pulmonary Disease and Degenerative Disc with pain. Review of the tenant's record reveals a cognitive evaluation dated 05-13-08 and the service plan dated 05-12-08. The service plan did not have signatures of the tenant, legal representative or two additional staff.

  Tenant #3, a 91 year old, had been admitted to the program 09-17-05 with diagnoses including: Arthritis and Left Hip Fracture. Review of the tenant's record revealed the functional, health and cognitive evaluations to be dated 09-17-07 and the service plan dated 09-16-07. The service plan did not have signatures of the tenant, legal representative or two additional staff.

  Tenant #4, an 87 year old, had been admitted to the program 02-01-02 with diagnoses including: Hypertension, Cerebrovascular Accident with left sided weakness, Chronic Foot Pain, Asthma and Acute Renal Failure. Review of the tenant's record reveals functional and health evaluations dated 02-12-08 and cognitive evaluation dated 02-12-07 and the service plan dated 05-12-08.

  Tenant #5, an 83 year old, had been admitted to the program 08-09-02 with diagnoses including: Rheumatoid Arthritis, Bilateral Knee Replacements, Lymphoma and L-2 Compression Fracture. Review of the tenant's record reveals cognitive evaluation dated 04-07-08 and the service plan dated 10-16-07. The service plan did not have signatures of the tenant, legal representative or two additional staff.

- Regulatory Insufficiency: The program did not consistently ensure a service plan would be developed for each tenant based on the evaluations conducted in accordance with 25.23(1) and 25.23(2), and shall be designed to meet the specific needs of the individual tenant. (25.28(1))

- Regulatory Insufficiency: The program did not consistently ensure that when a tenant needs personal care or health related care, the service plan would be updated within 30 days of occupancy and as needed, but not less than annually, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff as appropriate to meet the needs of the tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and if applicable, with the tenant's legal representative. (25.28(3))

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. [231C.16A]

Incident Allegation: The program reported on 06-02-08 medication irregularities were discovered during a routine narcotic count. The irregularities involved narcotic medications with Tenants #1, #2, #3, #4 an #5.

- Monitoring Observation: Review of program investigative documentation reveals numerous pages of the program narcotic count log to have been altered by photocopy and forged signatures. Changes were made with what appeared to be white-out material. The program investigation of the log material led to Staff #1, a medication manager, who contacted the program nurse on 06-02-08 and apologized, stating he had a huge problem. Staff #1 contacted the program nurse again on 06-06-08 and informed her he wanted to be placed in a drug treatment program. Program documentation included contact with the Sheldon Police Department and involvement of Officer Rob Hegenbarth who had informed the program that Staff #1 was in the hospital. Staff #1 had a toxicology screen which had come back positive for Fentanyl and two or three Class 2 narcotics, which the officer could not identify. At the time of the investigation, the program did not have documentation of the Police Department's report. Program documentation states Staff #1 had contacted the program nurse again on 06-04-08 inquiring if there were any legal charges against him at that point. The program nurse asked the employee what mediations he had taken and was told "you only have to worry about Fentanyl patches and the Staff #1's grandmother's Hydrocodone.

  An interview was conducted with the program nurse on 07-07-08. She stated the situation had been discovered on 06-02-08 by Staff #2 and #4 during narcotic count at shift change. The staff had discovered a change in the count of Fentanyl patches with no documentation of the medication being given. The staff also found forged signatures and narcotic count sheets photocopied. The program nurse stated some of the signatures were clearly not those of the staff and in some instances names were misspelled. She confirmed that during telephone conversations with Staff #1, he had stated he had taken Hydrocodone belonging to his grandmother, who is a tenant at the program, and replaced it with Tylenol. The program nurse stated the employee gave no indication of how long he had been doing this. She confirms four tenants were receiving Fentanyl at the time of the incident including Tenants #1, #2, #3 and #5. The program nurse confirmed that during telephone conversation with Staff #1 he had stated the only thing she had to worry about was the Fentanyl patches and his grandmother's Hydrocodone, and that he had spoken to her about the Hydrocodone. The program nurse stated she had not notified the pharmacies in regard to the incident.

  An interview was conducted at the program with Staff #2. Staff #2 stated that on 06-01-08 while doing the counts with Staff #3 they noticed problems with the count sheets and signatures. Staff #2 stated many of the signatures did not look like her handwriting. Staff #2 stated Staff #1 did a lot of the filing and handling of the records. Other staff just checked the numbers from the last shift and counted so they

never noticed the problem until 06-01-08, with the count being wrong for Tenant #3. Staff #2 also stated the program nurse had checked the prescription medication Ultram, belonging to Tenant #2 and found some of them missing. Staff #2 stated she did not know how many were missing. Staff #2 stated she had reported it to the program nurse, and she also denied taking any of the missing medications.

An interview was conducted with Staff #3 on 07-07-08. Staff #3 stated she had discovered the documentation and count errors while doing counts with Staff #2. Staff #3 stated they had noticed count sheets had been photocopied and signatures forged on the date of 05-31-08, which caught her attention as she had not worked on that date. Staff #3 stated observation of the count sheets revealed the sheet for Tenant #3 had dates going from 05-02 through 05-31. Review of the count sheets revealed the pages had been moved around to avoid detection by oncoming count staff. Staff #3 stated she had been contacted by the Sheldon police officer, Rob Hegenbarth and asked if she could figure out how many of the signatures were not hers. She found between one hundred and one hundred and forty five with many of the signatures misspelled. Staff #3 reviewed copies of the count sheets and marked some examples of the signature forgeries with a yellow highlighter as examples. Staff #3 also pointed out that Tenant #2 had not been on Fentanyl until some time in March or May. The whole page of the count sheet for the tenant had been altered with white out and changed. Staff #3 stated she knew nothing of the Ultram for Tenant #2. She believes the tenants always got their pain medications and denied taking any of the missing medications.

An interview was conducted with Staff #4 on 07-09-08. Staff #4 stated she had come to the program on 06-02-08 to check documentation on the narcotic count sheets for forged signatures, but could not say if there were any for sure. Staff #4 stated on 06-03-08 she had been asked by Tenant #4 to assist with opening pill bottles to fill cassettes which the tenant manages on his/her own. Staff #4 stated the tenant's grandson, Staff #1, usually helped the tenant with this. Staff #4 stated when the tenant's bottle of Hydrocodone was opened, it contained Acetaminophen and it appeared to be all Acetaminophen. While Staff #4 stated she did not look at all the pills in the bottle, she could see through the bottle and it appeared the pills were all Acetaminophen. Staff #4 stated she could not say how long the container had been in the tenant's possession. Staff #4 stated she had reported the observation to the program nurse. Staff #4 stated she had not observed any of the other staff taking the tenant's medication and denied taking any of the missing medications.

Contact was made with the Sheldon Police Department on 07-07-08. The Chief stated Officer Hegenbarth was not working but did contact him by telephone. Officer Hegenbarth stated he had not completed the report regarding the incident as he had been unable to contact Staff #1.

An interview was conducted with Staff #5 on 07-07-08. Staff #5 stated she had been made aware of the problem by Staff #2 and #3 and the program nurse. Staff #5 stated she had no knowledge of the situation but thought there were signatures that were not hers. She reviewed copies of the count sheets and marked signatures she believes were not hers with a pink dot as examples. Staff #5 stated she was not aware of any tenant complaints regarding medications or of the medications not being effective. Staff #5 denied taking any of the missing medications.

An interview was conducted with the Administrator on 07-08-08. She stated the Fentanyl patches were taken from the program medication room. It appears 13 patches were missing, but it is hard to tell for sure because the records were tampered with. She stated the missing Ultram medication was also from program stock and the tenant involved always received the medication. She stated the program did not drug test any staff, as it seemed obvious that it was Staff #1, as he had admitted it. He was drug tested and told the program nurse he had taken the Fentanyl and his grandmother's Hydrocodone. She stated there was no way of knowing how many pills of Tenant #4's Hydrocodone were missing as she handles her own medications. She stated she believes the tenants were billed for the missing medications and the pharmacies were not notified. She stated Tenant #1's medications are through Medicare D, Tenant #2's medications are through Title 19 and Medicare D, Tenant #3 had insurance supplemental, Tenant #4's medications are through Title 19 and Medicare D and Tenant #5's medications are through Medicare D.

Review of the medication count sheets for Tenant #1 reveals missing unaccounted for Fentanyl patches, on 03-23-08, 05-23-08 and 05-25-08, for a total of three missing patches. An interview with Tenant #1 on 07-08-08 reveals the tenant receives patches and medications on time with no problems.

Review of the medication count sheets for Tenant #2 reveals Fentanyl patches missing and unaccounted for with two patches missing on 04-17-08. Prescription medication Ultram, ordered for Tenant #2, and missing from program stock, with 56 tablets missing. An interview was conducted with Tenant #2 on 07-08-08. Tenant #2 stated he/she has never had any problems with medications and gets his/her patches as scheduled, as well as Ultram, with no problems. Review of physician records reveals Tenant #2 was started on Fentanyl 03-17-08; the altered count sheet for the tenant started with the date of 12-13-07.

Review of the medication count sheets for Tenant #3, who was discharged from the program on 06-14-08, reveals missing and unaccounted for Fentanyl patches on 04-21-08 (1 missing), 05-11-08 (1 missing), 05-23-08 (1 missing) and 06-01-08 (1 missing).

Review of medication count sheets for Tenant #5 reveals missing and unaccounted for Fentanyl patches on 03-17-08 (1 missing), 03-27-08 (2 missing), 04-26-08, 05-19-08 (1 missing) and 05-29-08 (1 missing). An interview was conducted with Tenant #5 on 07-08-08 and the tenant stated patches are on schedule and always works as expected.

The program reported 13 Fentanyl patches to be missing and unaccounted for.

Staff #1 was contacted by cell phone on 07-07-08, and declined an interview.

- Regulatory Insufficiency: None noted.

Dated this 29th day of July, 2008.