IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint: #24347-I

August 24, 2009

Annette Grochala, Administrator
Windsor Manor Assisted Living
608 S 15th St
Indianola, IA 50125-2981

RE: Complaint Investigation Report, Windsor Manor Assisted Living, Indianola, IA

Dear Ms. Grochala:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated July 27 & 28, 2009. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary

We appreciate your prompt action in correcting the Regulatory Insufficiency If you have questions, please contact me at 515-281-5003

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau
Connie.Schaffer@dia.iowa.gov

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

Assisted Living Program: **Complaint Intake: #24347-I**

Annette Grochala, Administrator
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA. 50125-2981

Date of Investigation:

July 27 & 28, 2009

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 incident investigation on-site visit was conducted at Windsor Manor Assisted Living on July 27 and 28, 2009 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	27
Current number of tenants with cognitive disorder	3
Total Population of GPP:	30

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP	9

Total Census of ALP: 39

***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 have not been any substantiated Regulatory Insufficiencies 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. [231C.16A]

Incident Allegation: It is alleged on 7-2-09 a local pharmacy delivered 180 tablets of Oxycodone 5mg for Tenant #1 On 7-13-09 the program nurse removed Tenant #1's Oxycodone 5mg from a locked drawer in the program nurse's office to fill the tenant's medication planner. On closer examination the program nurse noted the Oxycodone 5mg tablets had been replaced with 81 tablets of Tramadol 50mg.

- Monitoring Observation: Tenant #1, an 81 year old, was admitted on 3-18-08 and has diagnoses of: Lung Cancer, Chronic Pain, Depression, Anxiety and Insomnia. There are two physician orders of Oxycodone; on 1-5-09, Oxycodone ER 10 mg three times daily and on 6-19-09, Oxycodone -5mg three times daily Service plan of 5-11-09 indicated the program nurse filled a "pill planner" with the tenant taking medications independently Pharmacy records of 7-2-09 indicated 180 tablets of Oxycodone 5mg was delivered to the program.

  The local pharmacist who filled the prescriptions stated medications are always delivered to the program. The pharmacy driver stated he would try and get to the program before 5·00 p.m. The pharmacy driver stated on 7-2-09 he arrived at the program between 3 45 p.m. and 4.30 p.m. He stated the medications are stapled in a bag. He then goes to the tenant's apartment, opens the bag and the tenant looks inside. The pharmacy driver stated the vial held "a lot of very small pills – probably filling half of the vial. He then took the medications and placed them on the nurse's desk. He told the program nurse the medications were on her desk.

  The program nurse stated on 7-2-09 a local pharmacy delivered Tenant #1's Oxycodone, but did not recall if she gave the Oxycodone to Staff #5 to fill Tenant #1's medication planner "but assumed she had." The nurse did not recall whether she checked the tenant's medication planner prior to 7-13-09 to see if the medication planner was filled. The nurse stated she has left the key in the drawer when she has left the office "for a second or two." The key is stored in a hidden place in her office in case medications were delivered and she was not at the program to receive them. Another staff would receive them and put them away A review of staff scheduled to work 7-2-09 through 7-13-09 indicated 23 staff had access to the key that was used to lock the tenant's medication. On 7-13-09 the nurse took Tenant #1's medication "basket" from a lock drawer located in her office in order to fill the tenant's medication planner The nurse stated when she opened the bottle of Oxycodone "it was very obvious that the pills in the bottle were not Oxycontin," as they were not the right size. The nurse contacted the pharmacy, gave the "lot number" and was told the medication in the bottle was Tramadol. The nurse stated she contacted the manufacturer of the Tramadol found in the tenant's prescription bottle of Oxycodone and their brand was not sold in Iowa. The nurse stated the program did not complete narcotic counts on narcotics placed in medication planners where tenants were self-medicating.

Staff #2 stated she did not have access to the drawer and did not know where the key was. She stated the nurse and Administrator only have access to the locked drawer

Staff #3 stated extra medications were stored in the bottom drawer in the nurse's office and the key was kept on top of the shelf where the drawer was located. Staff #3 stated she would "often" see the key left in the lock.

Staff #5 stated on 7-2-09 "around 5.30 p.m." the nurse gave her a bottle of medications for the tenant and filled the tenant's planner, filling "some of the first week" and "all of the second week," and "immediately" put the bottle in the bottom drawer in the nurse's office and placed the key on top of the cabinet and was accessible to anyone She stated the pills, to her knowledge, put in the planner were Oxycodone 5mg tablets. Staff #5 stated narcotics given to tenant by staff are counted at each shift, but narcotics placed in "pill planners are not counted."

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

The tenant's file indicated two physician's order for Oxycodone; on 1-5-09, Oxycodone ER 10 mg three times daily and on 6-19-09, Oxycodone 5mg three times daily Pharmacist's statement of 1-6-09 through 7-27-09 indicated Oxycodone 10mg – 40 tablets were dispensed on 1-9-09. No other orders for Oxycodone were dispensed until 4-27-09 when the pharmacy dispensed 90 tablets of Oxycodone 5mg. The nurse stated she did not have an order for Oxycodone 5mg tablets – two tablets-three times daily until she received a physician's order for Oxycodone 5mg-two tablets three times daily until 6-19-09 The nurse stated the tenant would go to his/her physician and obtain prescriptions for medications; and she wouldn't have a physician order for medications that she placed in the tenant's medication planner, including Oxycodone. On 5-15-09, pharmacy delivered 180 tablets. On 6-8-09 pharmacy delivered 180 tablets of Oxycodone. On 7-2-09 the pharmacy delivered 180 tablets of Oxycodone. On 7-13-09 the program reported the Oxycodone delivered on 7-2-09 was missing and had been replaced with 81 tablets of Tramadol. On 7-16-09 pharmacy delivered 180 tablets to replace the tablets that were missing on 7-13-09 According to Staff #5 she filled the tenant's medication planner on 7-2-09 and filled "some of the first week and all of the second week." Because the program did not complete a narcotic count of the tenant's Oxycodone the number of Oxycodone tablets is unknown.

The nurse stated over the last three times she had filled the tenant's two week medication planner she had noticed the tenant had missed two or three pills. Giving the reason for missed pills, were the pills are white and hard for the tenant to see in the bottom of the planner, which is also white. During the last medication planner fill she had noted three slots where the tenant had missed taking the medications. The nurse stated "there is a trend for missed medications" by the tenant.

The program did not follow an acceptable medication protocol and did not complete narcotic counts of narcotics given to tenants, ensuring accountability by the tenant in taking the medications and for staff administering medications.

- Regulatory Insufficiency· The program did not consistently provide the administration of medications by an Iowa-licensed registered nurse or advanced

registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655-subrule 6.2(5) and 655-subrule 6.3(1) and Iowa Code chapter 155A and in executing the medication regimen as prescribed by the physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules. (25.29 (a), 655-6.2 (5) (e) (152)

Dated this 24th day of August, 2009