IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

October 21, 2009

Incident #24802-I

Ms. Cathy Morel, Administrator
Amber Ridge Assisted Living
107 E 2nd St
De Witt, IA 52742-2140

RE: Incident Investigation Report, Amber Ridge Assisted Living, De Witt, IA

Dear Ms. Morel:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Incident Investigation Report dated September 15, 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 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

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

Assisted Living Program: **Incident Intake #: 24802-I**

Ms. Cathy Morel, Administrator
Amber Ridge Assisted Living
107 E 2nd St
De Witt, IA 52742-2140

Date of Incident Investigation:

September 15, 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 an 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 Amber Ridge Assisted Living on September 15, 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:	20
Current number of tenants with cognitive disorder:	0
Total Population:	20

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 complaints this certification period in the areas of: Evaluation of Tenants, Service Plans, Nurse Review, Staffing and Record Checks.

Incident Investigation – The 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 shall be appropriately supervised and administered. Medications are appropriately stored.

Incident Allegation: The program reported Tenant #1's narcotic count sheet used for recording administration of Fentanyl, 12.5 mcg, one patch every 72 hours, was completed incorrectly. A local pharmacy delivered three Fentanyl patches on 7-27-09 and on 7-29-09 delivered seven additional patches. On 7-29-09 Staff #2, administered a Fentanyl patch and recorded that one patch was available and threw away the box, indicating no patches remained. Staff #2 did not search through the tenant's medication box and did not count the seven patches delivered earlier in the day. On 8-2-09 Staff #1 found seven Fentanyl patches but the narcotic count sheet indicated there should have been three available.

Monitoring Observation: Tenant #1, 86 years old, was admitted on 4-1-07 and had diagnoses of: History of a Fractured Femur with Hip Pinning, History of Pneumonia, Weakness, Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Osteoporosis, Urinary Frequency and Chronic Obstructive Pulmonary Disease (COPD). A physicians order dated 3-30-09, indicated the tenant received Fentanyl, 12mcg/hr, apply one patch daily every 72 hours. Medication Administration Records (MARs) for July, 2009 indicated the tenant was administered Fentanyl, 12mcg at 8:00 p.m. on 7-26-09, by Staff #3. A narcotic count sheet used to record the administration of Tenant #1's Fentanyl confirmed one patch was used on 7-26-09 with one patch remaining. Staff #4 confirmed three Fentanyl patches were received from the pharmacy on 7-27-09. She stated three Fentanyl patches were delivered in a small bag which she folded and placed in the box with the one remaining Fentanyl patch. A total of four patches were counted and recorded on the narcotic count sheet.

Tenant #1's MARs for 7-29-09 indicated Staff #2 administered a Fentanyl patch to the tenant on 7-29-09. She recorded a late entry, dated 8-3-09, on the narcotic count sheet indicating the use of one Fentanyl patch on 7-29-09 and no Fentanyl patches remaining. Staff #2 stated she took one Fentanyl patch from the box in which the Fentanyl patches were kept, noticed the box was empty and threw the empty box away. She stated the late entry on the narcotic count sheet was made as she was told she had not recorded the use of the Fentanyl patch on 7-29-09.

Pharmacy records dated 7-29-09 indicated seven Fentanyl patches were delivered to the program but the program did not record delivery of the seven patches on the narcotic count sheet until 8-2-09 when a new narcotic count sheet was started. Narcotic counts of Fentanyl patches and MARs were accurate from 8-2-09 forward. A dependent adult abuse investigation was conducted and local police are investigating.

The program did not accurately count the number of Fentanyl patches remaining on 7-29-09, did not complete narcotic counts to applied standards of counting and recording the use of narcotic medications and did not record the delivery of new narcotic medications to narcotic count sheets when received.

- 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. (IAC r. 321-25.29(a); IAC r. 655-6.2(5)(e)) (implementing Iowa Code chapter 152).

Dated this 21st day of October, 2009.