IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

**Certified**
**Complaint: #25282-I**

December 14, 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:

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 515-281-5003.

Sincerely,

Connie Schaffer

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

Enclosure

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

**Assisted Living Program:** **Incident Intake:** #25282-I

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

**Date of Incident Investigation:**

October 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 Windsor Manor Assisted Living on October 15, 2009. In preparing this report, the following information was considered:

**Current Program Census:**

***General Population Program (GPP)**** – A program that is not include a Dementia Specific program, but may have tenants with cognitive disorder.

| | |
|---|---|
| Current number of tenants without cognitive disorder: | 25 |
| Current number of tenants with cognitive disorder: | 5 |
| 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 been substantiated Regulatory Insufficiencies in the areas of: Medications and Staffing during this recertification period.

**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 is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Incident Allegation: The program reported Tenant #1 requested the program nurse to call a local pharmacy to refill his/her Oxycodone. The pharmacy indicated 84 Oxycodone tablets were delivered on 9-2-09 and the tenant should not need a refill until 9-16-09. The program nurse went to the tenant's apartment and noted only four Oxycodone tablets were remaining.

- Monitoring Observation: Tenant #1, an 81 year old was admitted to the program on 3-18-08. The tenant has diagnoses of: Lung Cancer, Depression, Anxiety, Insomnia, Chronic Pain and Peripheral Neuropathy. The tenant scored a three on the Global Deterioration Scale of 9-10-09, which indicates mild cognitive decline, early confusion of 9-10-09 Physician's order of 6-19-09 indicated an order was written for Oxycodone 5mg tablet, two tablets three times daily. On 7-27-09, a managed risk agreement was initiated allowing staff to fill medication planners with the tenant self administering his/her own medications. Nurse's care notes of 7-28-09 indicated a managed risk agreement was initiated as the program nurse was filling the tenant medication planner and noted the tenant had not taken all of his/her medication.

  On 8-19-09 the managed risk agreement was revised to allow the tenant's pharmacy to place a two-week supply of medications in bubble packs and for the program nurse to follow-up weekly for one-month to assure the tenant understands and correctly uses the bubble packs. The agreement noted the tenant had been missing medication and trying to obtain medication refills on as needed medications before they were available because the tenant had taken more than the prescribed dose.

  Nurse care notes of 8-19-09 and 9-1-09 indicated the tenant was taking the medications as ordered by the physician. On 9-9-09 the tenant told the program nurse he/she was getting low on Oxycodone 5mg tablets and requested the program nurse to call the pharmacy for a refill. The pharmacy told the program nurse they had delivered 84 tablets of Oxycodone 5mg tablets to the tenant on 9-2-09. Nurse's notes of the same entry indicated the program nurse and Administrator went to the tenant's apartment and found the tenant had cut up the bubble packs of Oxycodone 5mg tablets into strips. The tenant reportedly indicated he/she did this in order to take the Oxycodone 5mg on outings away from the program. Pharmacy records of 9-2-09 indicated the tenant had signed for 84 tablets of Oxycodone 5mg. Nurse's notes of 9-10-09 indicated the tenant told the program nurse he/she takes Oxycodone 5mg tablets at breakfast, lunch, and supper and sometimes at night. Please note the physician's order for Oxycodone 5mg is three times daily.

  The tenant was interviewed and confirmed he/she had cut the bubble packs of Oxycodone 5mg into strips. The tenant stated he/she would put some in his/her purse as he/she would spend a couple of days away from the program at a friend's house. The tenant confirmed he/she had taken Oxycodone 5mg tablets in the morning, at lunch and supper and sometimes at night. Nurse's notes of 9-10-09 indicated the

tenant agreed to let the program administer medications. The tenant's service plan of 9-10-09 indicated the program administered medications to the tenant.

- Regulatory Insufficiency: None noted.

Dated this 14th day of December, 2009.