IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Certified
Incident: #25998-I

January 21, 2010

Elaine Helgeson, Administrator
Mills Harbour Independent and Assisted Living
311 S 10th Ave E
Lake Mills, IA 50450-1870

RE: Incident Investigation Report, Mills Harbour Independent and Assisted Living, Lake Mills, IA

Dear Ms. Helgeson:

Enclosed is the **Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C (2009) and 481 Iowa Administrative Code, chapters 67 and 69, pertaining to assisted living programs and 481—67, 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 #: 25998-I**

Elaine Helgeson, Administrator
Mills Harbour Independent And Assisted Living
311 S 10th Ave E
Lake Mills, IA 50450-1870

Date of Incident Investigation:

January 6, 2010

Monitor(s):

Joyce Kix, 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. IAC r. 481-67.10(5). 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 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Mills Harbour Assisted Living on January 6, 2010. 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:	39
Current number of tenants with cognitive disorder:	1
Total Population:	40

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.

Program History – There have been no substantiated Regulatory Insufficiencies during this recertification period.

On-Site Monitoring Evaluation – The monitor made the observations detailed in the following areas.

A. Other

Incident Allegation: The program reported on 10-21-09 that three different tenants had medications identified as missing from the medication cart 10-20-09.

- Monitoring Observation: The program initiated an investigation involving local police enforcement on 10-20-09 and were unable to identify exactly how or when the medications went missing. The pharmacy reports indicated that the medications for the three tenants were delivered to the facility: Tenant #1 on 9-29-09, 30 tablets of Klor-Con, Tenant #2 on 10-13-09, 60 tablets of Glyburide, and Tenant #3 on 10-13-09, 90 tablets of Hydrocodone. Staff #1 stated that on Tuesdays she sets up medications for the three tenants. On 10-20-09 Staff #1 took the medication cart to the second floor to set up medications and denies the cart was left unattended at any time while unlocked. At this time Staff #1 identified that Tenant #3's bottle of Hydrocodone was missing at that time. Upon further inspection, it was identified three different tenants had missing medications from the top drawer of the medication cart. Staff #1 remembered all medications were there on 10-13-09 for medication set-up. The medication cart is routinely kept in the locked medication room on the first floor. All staff of the assisted living and the nurses from the attached nursing home have access to the keys to both the cart and the medication room. Review of the staff schedules of both entities reveals at least 16 people had opportunity and access to the medications from the time period of 10-13-09 to 10-20-09. All staff interviewed denied involvement in the alleged theft of medications. The monitor was unable to determine if the medications were inadvertently disposed of or misappropriated. No perpetrator could be identified.

- Regulatory Insufficiency: None noted.

Dated this 21st day of January, 2010.