IOWA DEPARTMENT OF

INSPECTIONS & APPEALS

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CHESTER J. CULVER
GOVERNOR

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DEAN A. LERNER, DIRECTOR

April 1, 2010

Incident: #27580-M

Demaris Luttenegger, Administrator
Senior Suites Assisted Living
4700 84th Street
Urbandale, IA. 50322-7352

RE: Final Incident Investigation Report, Senior Suites Assisted Living, Urbandale, IA

Dear Ms. Luttenegger:

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code 231C.7 (2010) and 481 Iowa Administrative Code, chapters 481—69, pertaining to assisted living programs and 481—67.12(3), pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

A copy of the monitor's **Incident Investigation Report** is enclosed for your information and as a record of the result of this investigation.

If you have any questions regarding this Report, please contact me at 515-281-5003.

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 27580-M**

Demaris Luttenegger, Administrator
Senior Suites Assisted Living
4700 84th Street
Urbandale, IA. 50322-7352

Date of Incident Investigation:

March 17, 18 and 22, 2010

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. 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 Senior Suites Assisted Living on March 17, 18 and 22, 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:	44
Current number of tenants with cognitive disorder:	0
Total Population:	44

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 certification period.

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

A. Medications

Incident Allegation: Tenant #1 suspected someone was getting into his/her medications. The program placed a video camera in the tenant's apartment. When the tenant reported someone other than the tenant had been into the medications the video tape was reviewed and revealed Staff #1 had opened and removed Hydrocodone 10mg/325mg tablets from two bottles that were placed in cabinet drawer.

- Monitoring Observation: Tenant #1, an 89 year old, was admitted on 12-16-09 and has diagnoses of: Rectal Cancer, Macular Degeneration and a History of Cerebral Vascular Accidents. The tenant was admitted to hospice on 12-6-09 with a diagnosis of: Increased Weakness and Fatigue. Nurse's notes of 12-16-09 indicated the tenant was admitted to respite care on 12-16-09 until 12-23-09. On 12-23-09 the tenant was admitted to the assisted living program.

  On 2-12-10 the tenant reported to the registered nurse (RN) a bottle of Hydrocodone 10mg/325mg tablets had been tampered with; the caps had been removed and placed differently on the bottles.

  Respite care apartments were located on the first floor adjacent to the residential care program and separate from the assisted living program. Staff from the adjacent resident care facility, provide cares to tenants in the respite program and the tenants' respite files were also located at the residential care facility. The tenant stated the apartment door in the respite program could not be locked. A service plan of 1-14-10 indicated the tenant was independent with medications, but needed assistance with bathing and occasional staff assistance with ambulation.

  The tenant stated he/she knew medications were missing before 2-12-10 because the cap of the bottle had been turned over; as he/she had asked a family member to place the cap on the bottle so they could be screwed on, as it was easier for the tenant to access the Hydrocodone tablets. It was observed the tenant's medication bottles had caps, which could be either screwed on or turned upside down and snapped over the bottle.

  Pharmacy records indicated Hydrocodone 10mg/325mg – 180 tablets was filled by a local pharmacy on 1-27-10. On 2-12-10 at 2:30 p.m. the RN counted 70 tablets in the bottle remaining. Tenant #1 stated he/she took one Hydrocodone 10mg/325mg tablet at 8:00 a.m., another tablet at 12:00 p.m. and did not take over two tablets daily. On 2-13-10 the tenant reported the cap to the bottle of Hydrocodone had changed twice, once when returning from breakfast and again when returning from lunch. On 2-15-10, the RN stated the tenant indicated he/she had taken five Hydrocodone 10mg/325mg tablets over the weekend and one tablet the morning of 2-15-10. With five tablets taken by the tenant, 20 tablets were unaccounted for. The RN counted the number of Hydrocodone 10mg/325 mg tablets and noted 45 tablets remained in the bottle.

  On 2-16-10 the tenant reported taking two Hydrocodone 10mg/325mg tablets. On

2-17-10 the tenant reported the bottle cap had been changed twice; once after returning from breakfast and again after returning from lunch. The tenant reported taking a total of four Hydrocodone 10mg/325mg tablets between 2-16-10 and 2-17-10. On 2-17-10 at 3:00 p.m. the RN noted the bottle cap on the Hydrocodone 10mg/325mg bottle cap had changed and counted 31 tablets remained in the bottle, with 10 tablets missing. On 2-17-10, pharmacy records indicated Hydrocodone 10mg/325mg – 60 tablets were delivered to the tenant. On 2-18-10, with the tenant's permission, a surveillance video camera was placed in the tenant's apartment.

On 2-19-10 the RN counted 31 tablets in the original bottle of 180 tablets of Hydrocodone 10mg/325mg and 60 tablets of Hydrocodone 10mg/325mg delivered on 2-17-10. A video tape was placed in the camera the same day at 5:55 a.m., 7:25 a.m. and at 11:00 a.m. At 12:45 p.m. the tenant indicated the bottle caps on the two bottles of Hydrocodone 10mg/325mg had changed. The RN went to the tenant's apartment, and counted the Hydrocodone 10mg/325mg tablets the two bottles. The bottle, which contained 31 tablets Hydrocodone 10mg/325mg, counted earlier that morning now contained 24 tablets, with seven tablets missing. The bottle, which contained 60 tablets of Hydrocodone 10mg/325mg, had 50 tablets remaining, with 10 tablets missing.

The RN and Administrator viewed the video tape and noted Staff #1 opening the tenant's medication drawer, removed the caps from two medication bottles, separately, and removed an unknown number of tablets from each bottle, placed the lids back on the bottles and placed the bottles back into the drawer.

Staff #1 was hired on 12-3-09 as a certified medication aide. The RN stated Staff #1 was hired as a certified medication aide to administer oral medications, complete prescribed treatments and provide assistance with direct patient care for residents in the residential care facility and to tenants who resided in the assisted living program from 11:00 p.m. to 7:00 a.m. On 1-28-10 Staff #1 sustained an injury to her hand, was placed on light duties and was taken off the nursing schedule. On 2-9-10 Staff #1 was assigned to work in the activities department while on light duty. Staff #1's time card indicated she had worked 2-12-10 from 12:30 p.m. to 7:15 p.m., 2-13-10 from 10:15 a.m. to 3:15 p.m., 2-16-10 from 10:30 a.m. until 7:30 p.m., 2-17-10 from 8:30 a.m. until 4:45 p.m.

On 2-19-10 the RN stated staff had seen Staff #1 in the building just before 12:00 p.m. and then left the building sometime between 1:00 p.m. and 1:30 p.m. The Administrator stated Staff #1 had been in the building for a monthly employee in-service but left as she had to take her son to a doctor's appointment. The RN called Staff #1 and asked her to return to the program. The RN and the Administrator asked Staff #1 why she had been in the building earlier since she was not scheduled to work. Staff #1 indicated she went back to the nurse's station as she had left her wrist brace and needed it for an appointment with her workmen's compensation appointment. The RN and Administrator asked Staff #1 if she had taken any medications from Tenant #1's apartment. Staff #1 stated she hadn't taken any medication from the tenant's apartment. The RN and Administrator showed the video of Staff #1 in Tenant #1's apartment, opening a drawer in a table, removing medication from the tenant's medication bottles and placing the bottles back in the drawer. Staff #1 stated she had taken four tablets, felt guilty and threw them away.

Staff #1 was working the days in which Hydrocodone was missing from the tenant's apartment and she was video taped taking medications from the tenant's medication bottles located in the tenant's medication drawer. Staff #1 was suspended and later terminated from employment.

- Regulatory Insufficiency: None noted.

Dated this 1st day of April, 2010.