IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint Intake: 34692-C
Incident Intake: 35139-I
34699-I

September 9, 2011

Bethany Clemenson, Manager
Windsor Manor Vinton
1807 W. 5th Street
Vinton, IA 52349

RE: Final Complaint & Incident Investigation Report, Windsor Manor Vinton, Vinton, Iowa

Dear Ms. Clemenson:

Enclosed is the **Final Complaint & Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint & Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Bethany Clemenson, Manager
Windsor Manor Vinton
1807 W. 5th Street
Vinton, IA 52349

Complaint Intake #: 34692-C
Incident Intake #: 35139-I
34699-I

Dates of Investigation:

August 9 & 10, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

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 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 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:

A complaint investigation and on-site visit was conducted at Windsor Manor Vinton on August 9 & 10, 2011. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS):	9
Current number of tenants without cognitive disorder:	27
Total Population:	36

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Medications

Incident Allegation #35139-I: The Program reported 10 pills of Hydrocodone 7.5/500 were missing from a tenant's as needed medication card.

- Monitoring Observation: Tenant #1 (the Tenant), an 89 year old, was admitted on 10-12-08 and diagnoses include: End Stage Renal Disease with Dialysis, Pneumonia, Congestive Heart Failure, Seizure Disorder, Anemia, Hypothyroidism, Hypertension (HTN) and Back Pain. The Tenant had an order for Hydrocodone-APAP 7.5/500 one tablet every day at bedtime. The Tenant also had an order for Hydrocodone-APAP 7.5/500 take one tablet by mouth every six hours as needed. According to the service plan, staff administered medications. The medications were locked in a cupboard or drawer in the Tenant's apartment and a pharmacy set up the medications.

  According to investigation notes, on 7-23-11 at approximately 7:00 p.m. Staff #5 informed the Manager that the count was short 10 on the Tenant's Hydrocodone-APAP 7.5/500. The Manager confirmed the count and made copies of the count

sheets. A full investigation was started and the missing medications appeared to be from the as needed Hydrocodone-APAP.

According to a Controlled Substance Usage and Count Sheet for the Tenant's Hydrocodone-APAP 7.5/500, on 7-21-11 at 7:15 p.m. Staff #5 and Staff #8 signed the record and indicated 36 pills were left. According to investigation notes, Staff #5 stated she counted with another individual each time she counted on her shifts. She was positive the count was correct on 7-21-11 at 7:15 p.m. Staff #8 reported she completed a medication count on 7-21-11 at 7:15 p.m. with Staff #5. She stated the count was correct.

According to a Controlled Substance Usage and Count Sheet, on 7-22-11 at 5:00 a.m. Staff #7 and Staff #10 signed the record and indicated 36 pills were left. Staff #7 stated she completed the count alone on 7-22-11 at 5:00 a.m. and the count was correct. Staff #10 stated she did not complete the narcotic count on 7-22-11 at 5:00 a.m. but signed off on it.

According to a Controlled Substance Usage and Count Sheet, on 7-22-11 at 9:00 a.m. Staff #3 and Staff #4 signed the record. The number left appeared to either be 26 or 36. Staff #3 reported she counted medications alone on 7-22-11 at 9:00 a.m. and recorded a 26 as a count but did not realize the count was off by 10 pills. When she reviewed the documentation she stated her number had been written over to be made into a 36. Staff #4 stated she did not count narcotics but signed after Staff #3 on 7-22-11.

According to a Controlled Substance Usage and Count Sheet, on 7-22-11 at 7:45 p.m. one pill was administered and Staff #6 and Staff #1 signed the record and indicated 35 pills were left. According to a Controlled Substance Usage and Count Sheet, on 7-22-11 at 8:00 a.m. Staff #6 and Staff #1 signed the record and indicated 34 were left. Staff #6 stated she did not complete a physical count on entries dated 7-22-11 at 7:45 p.m. but signed off using the numbers entered above. Staff #1 stated she did not visually count the pills at 7:45 p.m. She said Staff #6 asked her to sign and she did. She also did not recall doing a count at 8:00 a.m.

According to a Controlled Substance Usage and Count Sheet, on 7-23-11 Staff #3 and Staff #9 signed the record and indicated 34 pills were left. No time was documented for the count. Staff #3 indicated on 7-23-11 she did not count but wrote in a total and signed. Staff #9 stated she did not complete the count on 7-23-11 but did sign off on it.

According to a Controlled Substance Usage and Count Sheet, on 7-23-11 at 7:45 p.m. one pill was administered and the count was 24. Staff #5 discovered the count was off and reported the discrepancy to the Manager.

All staff who had access to the medication key or drawer during the time of suspicion consented to a drug test and all were negative, according to investigation notes. Staff #1, #3, #4, #5, #6, #7, #8, #9 and #10 stated they had no knowledge of the missing medication.

The Program's policy regarding narcotic count was reviewed. Narcotics administered by the Program were counted with the narcotic count sheet. Staff was responsible to count and record the total number of narcotics at the end/beginning of each shift and after the administration of any narcotics. All medication managers were required to complete a thorough check of the Medication Administration Records (MARs) and narcotic counts at the end of their shift with another staff member. All discrepancies would be dealt with immediately with a call to the Nurse when necessary.

Staff did not follow the narcotic policy. Staff did not consistently complete a thorough check of the medications; however, they signed that the medications had been counted. Staff also did not consistently count with two staff members; however they signed that the medications were counted with two staff members. Staff did not report all discrepancies to the Nurse. The narcotic count record had an entry where time was not recorded for one of the counts. Staff did not consistently complete appropriate narcotic counts and accurately complete documentation related to the counts.

It could not be determined what happened to the missing medication at the time of the investigation. An incident report was completed and the Program contacted the local police department and the Department.

The Tenant was informed of the missing medication and was reimbursed for the medication, according to the Manager.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

B. Nurse Review

Complaint Allegation #34692-C: It was alleged a tenant's medications were not administered per physician's orders. It was alleged a tenant had a change in condition and it might not have been followed up on appropriately.

- Monitoring Observation: Five tenant files were reviewed.

The file was reviewed for Tenant #1 (the Tenant). On 6-3-11 Tylenol and Tramadol were discontinued and Ativan was changed from everyday at bedtime to as needed. These changes were reflected on the MAR. The medications were documented as administered per physician orders. On 6-13-11 Hydrocodone-APAP 7.5/500 at bedtime was ordered. This was reflected on the MAR and was documented as administered per physician order. On 8-2-11 an order was received to change the Lidoderm patch at bedtime and remove in the morning. This was reflected on the MAR and was documented as administered per physician order. Physician orders were followed consistently and nurse reviews were completed as needed.

Tenant #2 (the Tenant), a 97 year old was admitted on 5-2-09 and diagnoses include: History of Back Surgery, HTN, Irregular Heartbeat, Depression and Insomnia. The Tenant received Hospice services. The Tenant was discharged on 7-4-11. Nurse's Notes dated 2-23-11 indicated the Tenant had bilateral lower extremity edema and the right big toe was painful and the toe was pink and slightly swollen. On 2-24-11 the Tenant was seen and an antibiotic was ordered for an infection of the right big toe. The Tenant stored and administered his/her own medications at that time. On 3-21-11 the Tenant was admitted to a hospital with a diagnosis of Cellulitis and returned to the Program on 3-23-11. The notes indicated the Tenant's right foot was slightly red and an open sore on the inner aspect near great toe required a dressing change twice daily. The staff administered the Tenant's medications after the return from the hospital. The Tenant was hospitalized with Cellulitis of the right foot on 5-14-11 and returned to the Program on 5-20-11. Notes indicated the Tenant had three open wounds. The Tenant met with a wound care nurse on 5-27-11. On 6-3-11 the wound care nurse was contacted regarding increased number of areas on right foot that had worsened. The wound care nurse explained the wound would continue to worsen due to poor perfusion. On 6-6-11 the physician was contacted regarding appearance of wounds and an antibiotic was ordered. The Tenant elected Hospice services on 6-18-11. The Nurse was called by staff to assess the Tenant on 6-20-11. The Tenant was unable to get out of bed due to pain. The open area on the great toe was open and dry. Necrotic areas were noted. The 4th and 5th metatarsals were black and no foul odor was noted. Notes indicated on 6-29-11 the Tenant did not bear weight on the right foot when transferring and the Nurse assessed the wounds. On 7-1-11 oral medications were held due to inability to swallow, pain medications were given for pain and restlessness and an end of life task sheet was initiated. The Tenant died on 7-4-11. Nurse reviews were completed appropriately with changes in health status and with new orders for medications and treatments.

A hospital Discharge Summary dated 5-20-11 showed when the Tenant returned from the hospital, Cefdinir 300 mg (antibiotic) capsule twice daily for five more days was ordered. The MAR reflected the medication was documented as administered per physician order. On 6-6-11 Cephalexin 500 mg (antibiotic) twice daily for 10 days was ordered. This was reflected on the MAR and was documented as administered per physician order. Physician orders were followed consistently and nurse reviews were completed as needed. The Hospice Nurse was contacted and stated the Tenant had a long term history of infection and physician orders were followed. She said the Tenant did not have an antibiotic ordered during the time he/she received Hospice services.

Tenant #3 (the Tenant), a 93 year old, was admitted on 2-2-08 and diagnoses include: Severe Diffuse Osteoarthritis, Chronic Severe Pain, HTN, Anxiety and Peripheral Painful Neuropathy. An order was received to resume previous Lortab dose 5/500 three times daily started on 5-23-11. The order indicated to discontinue Fentanyl Patch upon removal of current patch 5-23-11. This was reflected on the MAR and was documented as administered per physician orders. Nurse reviews were completed appropriately. Physician orders were followed consistently and nurse reviews were completed as needed.

Tenant #4 (the Tenant), a 92 year old, was admitted on 5-1-09 and diagnoses include: Dementia, HTN, History of Falls, Diabetes Mellitus and History of Knee Pain. The

Tenant was staged a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The Nurse's Notes on 7-25-11 reflected staff reported the Tenant seemed more confused. A request to the Tenant's physician was made for a Urinalysis. On 7-26-11, a urine sample was sent to the lab for culture. A new order was received on 7-29-11 for an antibiotic for a Urinary Tract Infection. The MAR reflected the medication was administered per physician order. Physician orders were followed consistently and a nurse review was completed as needed.

Tenant #5 (the Tenant), an 82 year old, was admitted on 5-27-11 and diagnoses include: Parkinson's disease, Chronic Obstructive Pulmonary Disease and Dementia. The Nurse's Notes on 6-8-11 stated the Tenant was sick, vomited and had diarrhea. Vital signs were taken; the Tenant appeared weak and confused. Upon standing, the Tenant was incontinent. Stand by assistance of two staff members was requested. The Tenant's physician was notified and an office appointment was scheduled. The Tenant was admitted to the local hospital for Intravenous Antibiotics after seeing the physician. Nurse reviews were completed as needed.

- Regulatory Insufficiency: None noted.

C. Other

Incident Allegation #34699-I: The Program reported a tenant had eloped from the building.

- Monitoring Observation: The file was reviewed for Tenant #4 (the Tenant). According to the Incident Report completed by Staff # 1 on 6-24-11 at 7:19 p.m., the Tenant had been walking in the halls with another tenant which was his/her normal routine. Staff #1 was in another tenant's apartment when she looked out the window and saw the Tenant walk by the window on the sidewalk. Two other individuals were walking with the Tenant, one was a family member of another tenant and the other was a person who lived nearby. Staff #2 was with Staff #1 and noticed the same thing. Staff #2 went outside to bring the Tenant back into the building. An Incident Report completed by Staff #2 on 6-24-11, stated the incident occurred between 7:00 p.m. and 7:30 p.m. She stated that she and a coworker were in another tenant's apartment when they saw the Tenant walking on the sidewalk with another person around 7:15 p.m. Staff #2 went outside and assisted the Tenant back to his/her apartment at approximately 7:20 p.m. The person walking with the Tenant who lived nearby stated he/she had seen the Tenant walking and was afraid the Tenant might fall so he/she walked with the Tenant. After assisting the Tenant back to his/her room, Staff #2 contacted the Nurse. The Tenant did not suffer any injuries.

  Staff #1 was interviewed. She saw the Tenant at approximately 7:00 p.m. while she was in another tenant's apartment and saw the Tenant outside the building. She saw the Tenant walking outside the building, using a walker and walking with another person. Staff #2 went outside to check on the Tenant and brought the Tenant back into the building. Visual checks had been completed every hour, with the last check at 7:00 p.m. After returning to the building the Tenant was visually checked every 30 minutes. Staff #1 could not remember what the Tenant was wearing but stated she was sure it was warm outside. Staff #1 stated there had never been any elopements

on her shift. She stated the Tenant did not incur any injuries. Staff #1 completed an incident report regarding the elopement.

Staff #2 was interviewed. She stated the Tenant had eaten dinner in the main dining room and returned to his/her apartment. The Tenant was walking with another tenant inside the building. She and Staff #1 were assisting another tenant when she saw the Tenant through the window walking outside with another person. She went outside to assist the Tenant into the building. She brought the Tenant through the west sunroom parking lot door. She thought the Tenant was wearing a blue shirt and pants. She stated the Tenant incurred no injures but seemed a little bit confused.

The Nurse was interviewed. She stated Staff #2 called her at approximately 7:45 p.m. on 6-24-11 to inform her that the Tenant was found outside near the sun room parking lot door. The Tenant was assisted back to his/her apartment. The Nurse contacted the Tenant's family member in regards to the incident. The Nurse and the Manager came to the Program approximately one hour later. Both the Nurse and the Manager interviewed Staff #1 and Staff #2 in regards to what occurred and if they had checked the alarm doors. The pagers indicated a door location whenever someone entered or left. It did not identify a tenant. Visual checks of the Tenant had been performed every hour prior to the incident and the last visual check occurred at approximately 7:00 p.m. The Nurse implemented 30 minute visual checks after the incident. Additional interventions implemented included retraining of staff in regards to elopements and more encouragement of the Tenant to stay in the building or take walks in the courtyard. Dining staff previously ended their work day at approximately 6:00 p.m. Since the incident dining staff now work until 9:00 p.m. in order to have more staff available in the evening hours. The Nurse stated the situation was handled appropriately and there was enough staff to meet the needs of the tenants.

The Manager was interviewed. She stated a staff member called her the evening of the incident and stated the Tenant was outside on the sidewalk nearest the Tenant's apartment talking with another tenant's family member. The staff member assisted the Tenant into the building. The Manager came to the building in order to determine how the incident happened. She interviewed staff and checked the pagers. She stated she was unable to determine how the elopement happened. Interventions established included visual checks every 30 minutes, retrained staff regarding elopements, redirection techniques and communication between staff. The Manager stated the Tenant had no other elopements. The Manager stated the situation was handled appropriately and there was enough staff to meet the needs of the tenants.

According to the State Climatologist on 6-24-11 at 7:15 p.m., the temperature was 70 degrees, with winds from the north/northwest at five miles per hour and clear skies.

Incident reports were completed related to the incident and the Department was notified of the incident appropriately.

- Regulatory Insufficiency: None noted.

Dated this 8th day of September, 2011.