IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 36906-I

January 19, 2012

Ms. Kylie Behm-Newhard, Administrator
Waterford Assisted Living
1325 Coconino Road, Suite 300
Ames, IA 50010

RE: Final Complaint/Incident Investigation Report, Waterford Assisted Living, Ames, Iowa

Dear Ms. Newhard:

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:

Kylie Behm-Newhard, Administrator
Waterford Assisted Living
1325 Coconino Road, Suite 300
Ames, IA 50010

Complaint/Incident Intake #: 36906-I

Date of Complaint/Incident Investigation:

December 21 & 22, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	45
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	47
TOTAL census of Assisted Living Program	47

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

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Medications

Complaint/Incident Allegation: The Program reported Hydrocodone belonging to Tenant #2, was missing. Three of Tenant #2's scheduled Hydrocodone 5mg/500mg Tylenol tablets were missing and four of Hydrocodone 5mg/500mg Tylenol tablets had been replaced with Tylenol between 11-17-11 and 11-18-11. Thirty three Hydrocodone 5mg/500mg Tylenol as needed (PRN) tablets had been replaced with Excedrin sometime between 7-24-11 and 11-18-11.

Monitoring Observation: Four tenant files were reviewed. Tenant #2, a 95 year old was admitted on 5-23-11 and had diagnoses of: Degenerative Joint Disease (DJD), Hypertension (HTN), Neuropathy, Lower Extremity Lymphedema, Atrial Fibrillation, Osteoporosis, Chronic Lower Back Pain, History of Compression Fracture and History of Shingles. A service plan of 6-22-11 indicated Tenant #2 was administered medications by the program. A physician's order of 10-5-11 indicated Hydrocodone 5mg/500mg Tylenol was ordered twice daily and every four hours as needed.

Tenant #2's narcotic count sheets for 11-18-11 at 6:00 a.m. indicated three PRN Hydrocodone 5mg/500mg Tylenol were missing. Staff #5 was interviewed and stated she worked the evening of 11-17-11 from 2:00 p.m. until 8:30 p.m. She completed a narcotic count of medication before leaving, but documented the narcotic count as completed at 10:00 p.m. She stated she left the keys on the couch in the medication room and left for the evening. Staff #6 stated she signed the narcotic count sheet on 11-17-11 at 10:00 p.m., indicating a narcotic count had been completed, but she didn't complete the narcotic count with Staff #5 at 10:00 p.m. Staff #1 worked 11-17-11 from 2:00 p.m.-10:00 p.m. and reported an end of shift/beginning of shift narcotic count wasn't done at 10:00 p.m. on 11-17-11.

The registered nurse (RN) noted in an incident report of 11-18-11, staff notified her of the missing PRN Hydrocodone 5mg/500mg Tylenol missing from Tenant #2's cassette. Upon visual inspection, the RN inspected the cassette and confirmed three Hydrocodone 5mg/500mg Tylenol were missing and noted four Hydrocodone 5mg/500mg Tylenol tablets had been replaced with Tylenol. The RN inspected two additional PRN cassettes belonging to Tenant #2 and noted 33 Hydrocodone 5mg/500 mg Tylenol tablets had been replaced with Excedrin tablets. The RN stated PRN Hydrocodone 5mg/500mg Tylenol was last given to Tenant #2 on 7-24-11. Narcotic count sheets confirmed the last PRN Hydrocodone 5mg/500mg Tylenol was given on 7-24-11 at 2:00 p.m. Narcotic count sheets from 7-24-11 through 11-18-11 indicated counts were completed for each shift and indicated no errors. The RN stated staff had been instructed to count narcotics at the beginning and end of each shift, but not to physically inspect the cassettes or bubble packs to determine if they had been tampered with.

Complaint/Incident Allegation: The Program reported 24 Hydrocodone 5mg/500mg Tylenol PRN tablets belonging to Tenant #3 were missing from a separate storage locker between 11-16-11 and 11-17-11.

Monitoring Observation: Tenant #3, a 79 year old, was admitted on 10-12-11 and had diagnoses of: Irritable Bowel Syndrome (IBS), Gastro Esophageal Reflux Disease (GERD), Macular Degeneration, Insomnia, Constipation, Osteoporosis, Anxiety, Hyperlipidemia, Atrophic Vaginitis, Allergic Rhinitis and Lumbar Spinal Stenosis. . A service plan of 6-22-11 indicated Tenant #3 was administered medications by the program. A physician's order of 11-16-11 indicated Tenant #3 was prescribed Hydrocodone 5mg/500mg Tylenol – one tablet every four hours PRN.

The RN and Staff #4 stated, in separate interviews, Tenant #3's Hydrocodone 5mg/500mg Tylenol PRN was packaged in a bubble pack sleeve and stored in a locker in the medication room, separate from the two narcotic lock boxes stored in the medication room. Two bubble pack of Hydrocodone 5mg/500mg Tylenol were in the locker on 11-16-11 at 3:00 p.m. The RN and Staff #4 stated they noted 24 Hydrocodone 5mg/500mg tablets were missing on 11-18-11. The locker had a combination lock and at least six staff had who administer medications had access and knowledge of the combination lock on the locker where the Hydrocodone was stored.

Complaint/Incident Allegation: The Program reported seven Hydrocodone 5mg/500mg Tylenol tablets belonging to Tenant #4 had been replaced with Tylenol sometime between 7-21-11 and 11-18-11.

Monitoring Observation: Tenant #4, an 89 year old, was admitted on 3-6-09 and had diagnoses of: History of Sinus Bradycardia, History of Colon Cancer, Coronary Artery Disease, Peripheral Vascular Disease, HTN, History of Myocardial Infarction and Gastro-Intestinal Ulcers. A service plan of 3-2-11 indicated Tenant #4 was administered medications by the program. A physician's order of 10-5-11 indicated Tenant #4 was prescribed Hydrocodone 5mg/500mg Tylenol-one to two tablets every four hours PRN. Narcotic count sheets of 10-10-11 to 11-18-11 indicated 16 Hydrocodone 5mg/500mg Tylenol were on hand. The RN stated she completed a

physical inspection of Tenant #4's Hydrocodone 5mg/500mg Tylenol on 11-18-11 and noted seven of the 16 tablets had been replaced with Tylenol.

Program records indicated the Program used an OPUS system for all scheduled medications. Scheduled narcotics were placed in each tenant's cassette and administered by staff. Narcotics scheduled as PRN were either in an OPUS cassette or bubble pack and were kept in a lock box in the Program's medication room. At the time of the incidents, two lock boxes were used. One lock box had a combination lock and the other had a key lock. Staff assigned to administer medications knew the combination and/or had a key to the lock box. A storage locker, located in the medication room, used to store additional narcotics that wouldn't fit in the narcotic lock boxes was also used.

Staff schedule for November, 2011 indicated three staff were scheduled routinely for the day and evening shift, from 6:00 a.m. to 2:00 p.m. and from 2:00 p.m. to 10:00 p.m. Two of the three staff members from the day and evening shift were assigned to administer medications to tenants. The night shift had two staff scheduled, with one staff assigned to administer medications. Staff schedule for 11-16-11 through 11-18-11 indicated at least five staff had access to Tenant #2, #3 and #4s' medication and access to PRN narcotics.

Staff #1, Staff #5, Staff #6, Staff #7 and Staff #8s' files were reviewed and indicated each had been trained by and demonstrated their competency to administer medications to the RN. A medication pass was observed along with a physical inspection of how narcotics were stored by the program. The medication pass and narcotic counts were completed appropriately and a visual inspection confirmed the placement of the narcotics stored by the Program in two lock boxes and a locked storage locker.

The Program's medication policy of 3-21-11 indicated two staff were needed to sign out and administer PRN narcotic medications to tenants. Narcotics were to be counted by two staff; one staff member from current shift and one staff from oncoming shift. This procedure was to be done for each of three shifts. Program documentation indicated a narcotic count was completed on 11-17-11 at 10:00 p.m. when Staff #5 and Staff #6 stated a narcotic count was not done, though each had documented it had been done.

- Regulatory Insufficiency: When medications are administered traditionally by the program: a. 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))